Indiana HIV/AIDS Housing Plan

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Executive Summary

This Executive Summary includes an overview of the needs assessment and planning process, the critical issues identified by the needs assessment process, the recommendations that were developed to address the critical issues and the key findings of the needs assessment.

The *Indiana HIV/AIDS Housing Plan* was completed in February 2003 for the Indiana Housing Finance Authority, the City of Indianapolis, and The Damien Center by AIDS Housing of Washington, a national HIV/AIDS housing technical assistance provider based in Seattle. The geographic focus is the state of Indiana, including the Indianapolis eligible metropolitan statistical area (EMSA).

Overview of the Needs Assessment and Planning Process

The needs assessment included the following components:

- **A Steering Committee** was convened in June 2002 to oversee and guide the needs assessment and planning process and was comprised of people living with HIV/AIDS, state and local government representatives, housing developers, AIDS housing and service providers, funders, social services providers, technical assistance providers, and advocates.
- **Interviews were held with nearly 140 stakeholders** working in areas related to HIV/AIDS housing and services.[1] These key informants were identified by the Steering Committee, community meeting participants, and other providers. Stakeholders in every region of the state as well as those working statewide were interviewed. Key informants were asked about the strengths and gaps of their local housing and service systems and for their ideas about possible improvements.
- **Eight consumer focus groups** were held with a total of sixty-four people living with HIV/AIDS in seven HIV Care Coordination Regions.
- **A written survey had 418 respondents** that included people living with HIV/AIDS in each region of the state.
- **A review of existing plans and data** related to housing, homelessness, and HIV/AIDS.

The *Indiana HIV/AIDS Housing Plan* provides a framework for assessing and planning for the housing needs of people living with HIV/AIDS. It represents the culmination of a nine-month effort by a broad cross section of stakeholders to determine the housing needs of people living with HIV/AIDS and their families throughout the state.

The plan includes a demographic profile of individuals who are estimated to be living with HIV and AIDS; an overview of income, housing affordability, and homelessness issues; an overview of HIV/AIDS-dedicated housing resources; findings from the focus groups, survey, and key informant interviews; and a summary of critical issues and recommendations.

[1] See the comprehensive list of key informants and agency affiliations at the front of this plan.

Critical Issues

The Steering Committee met over two days in January 2003 to review the findings from the needs assessment, identify the most critical issues concerning housing people living with HIV/AIDS in Indiana, and develop recommendations to address the critical issues. The issues were grouped into five themes.

Comprehensive and Collaborative Statewide and Local Planning

The Steering Committee and many stakeholders acknowledged that **strong and effective housing and service systems** are currently in place throughout Indiana. These assets create a solid base for providing housing and services to people with disabilities and/or low incomes in Indiana.

Although HIV/AIDS service organizations identify housing as a significant need of people living with HIV/AIDS, **linkages between the HIV/AIDS services and mainstream housing systems need improvement**, particularly at the planning level. As a result, stakeholders working in housing and homelessness have limited understanding of HIV/AIDS housing needs in their communities, although many expressed an interest when interviewed.

HIV/AIDS service organizations are generally **not as aware of programs and funding sources for housing** as they are of programs and funding sources for services. Most HIV/AIDS service organizations turn primarily to Housing Opportunities for Persons with AIDS (HOPWA) funds for housing resources. Although a critical source of support, HOPWA funds are extremely limited compared to the scope of other housing programs for people who earn low incomes. Participating in local planning processes is an excellent way to share and obtain information about available resources.

The Steering Committee emphasized several philosophies in regards to housing planning. There is a growing sense that a **"housing first"** approach—addressing housing needs prior to service needs, rather than requiring participation in or completion of services as a requirement for housing—is most appropriate for people living with HIV/AIDS, as well as other populations. In addition, both providers and consumers identified **permanent housing as a priority**, particularly **independent housing that is integrated into the community, whether rented or owned**.

Finally, the Steering Committee acknowledged that there is already **more need for housing and services than current levels of state and federal financial support can address**. Planning must include responses to the lack of resources, both by prioritizing the use of limited resources and by seeking new resources.

Affordability

The Steering Committee, consumers, and other stakeholders all identified **affordability as the primary barrier to accessing housing for people living with HIV/AIDS**. In every region of the state, it is extremely difficult to find decent, safe, and sanitary housing that is affordable for people with low incomes. **Deposits and other move-in costs** also impact affordability.

The resulting need for affordable housing and housing assistance by people living with HIV/AIDS and other people with low incomes, including people with disabilities, has created demand that greatly exceeds supply. As a result, many areas of the state often have **lengthy waiting lists** for the few housing opportunities that exist.

Barriers to Achieving and Maintaining Housing Stability

In addition to a lack of affordable housing, the Steering Committee, consumers, and providers identified several significant barriers to achieving and maintaining housing stability. The barriers identified most frequently by providers were **poor credit, recent criminal history, poor rental history**, and **active substance use.**

Consumers and providers also frequently referred to **confidentiality** as a concern in achieving and maintaining housing stability. Specifically, consumers were fearful that, upon discovering their HIV status, property managers and neighbors would react negatively, possibly with eviction or harassment.

Both providers and consumers agreed that **administrative requirements**, such as applying for programs and maintaining eligibility, can be challenging for some consumers, particularly those with low literacy levels, and as a result require more time and effort of direct service providers.

Successful Tenant-Landlord Relationships

The Steering Committee identified successful tenant-landlord relationships as another critical component of housing success. Both consumers and providers expressed concerns that a lack of **understanding about rights and responsibilities** can lead to housing problems. Seventy percent of survey respondents indicated that they would use legal help to deal with past or current housing problems, such as eviction, if available.

Confidentiality was the aspect of successful tenant-landlord relationships mentioned most frequently by consumers. Consumers suggested that property managers who accept HOPWA be required to sign a confidentiality agreement that would protect the tenant. **Housing quality** was also discussed. In some communities, the housing that is most affordable to people with very low incomes may be of low or even substandard quality.

Access to Community and Support Services

Some consumers have difficulty accessing services even though these services are offered in their community, mostly due to **challenges with transportation**. Half of survey respondents reported traveling 11 miles or more for medical and service appointments, and the majority depended on the car of a friend or family member to access appointments.

As people with HIV/AIDS live longer and healthier lives, **employment** is increasingly an area of interest for both consumers and providers. In focus groups, consumers expressed an interest in having employment opportunities that would both increase their income and allow them to contribute in their community. At the same time, both providers and consumers highlighted the critical importance of maintaining eligibility for medical benefits.

Recommendations

Steering Committee members had the opportunity to brainstorm and develop recommendations in response to the findings of the needs assessment. In addition, the ideas of people living with HIV/AIDS, summarized in the "Focus Group Findings" section of the plan, were presented to and discussed by the Steering Committee. Participants built consensus for seven recommendations to address the critical issues, then prioritized them by level of importance.

The recommendations are listed below as they were prioritized by the Steering Committee.[2]

1. Seek additional sources of funding to expand housing options along the HIV/AIDS housing continuum.

- Additional funding sources for housing programs include HOME, Community Development Block Grants (CDBG), Shelter Plus Care, Supportive Housing Program, Emergency Shelter Grants, Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, and others.
- New housing programs should be developed based on the needs and preferences identified by consumers during this planning process.
- New housing programs should be developed based on the needs identified for each region of the state.

[2] See Appendix 13 for minutes from the January 16, 2003 Steering Committee meeting, which includes a list of recommendations and the number of priority votes each recommendation received.

2. Create a statewide committee to coordinate HIV/AIDS housing planning.

- The mission of the committee is to guide the implementation of the plan's recommendations, as well as to provide educational and technical assistance on HIV/AIDS housing issues throughout the state.
- The Committee should have representatives from each region of the state and should explore possible structures for participation in order to choose the most appropriate and effective model.
- The Committee should have broad participation in order to engage many stakeholders in developing solutions. Participants should include HIV/AIDS housing and services providers, people living with HIV/AIDS, mainstream housing providers (such as developers and housing authorities), property managers, disability service providers, state and local government representatives, and funders.

3. Encourage HIV/AIDS service organizations and other providers that serve people with disabilities to participate in housing and homelessness planning efforts, such as the Consolidated Plan, Continuum of Care and public housing planning processes.

- The recommended statewide HIV/AIDS housing committee should educate stakeholders about the importance of participating in these planning processes.
- Information gathered during this needs assessment and planning process regarding the housing needs of people living with HIV/AIDS should be highlighted during these planning processes.

4. Develop a tenant-landlord education program that could be implemented in each HIV Care Coordination Region of the state.

- The goal of this program is to reduce barriers to accessing housing.
- Investigate model programs from throughout the country, including Fort Wayne's Gold Star Landlord-Tenant program.
- Explore potential funding options for this program.

5. Improve local service coordination among providers in each HIV Care Coordination Region of the state.

- Promote an exchange of information between HIV/AIDS housing and service providers and providers from other services systems, such as homeless, mental health, substance use, and other systems serving people with special needs.
- Seek opportunities to collaborate in planning and in creating housing for people with special needs.

6. Increase housing opportunities for people with barriers related to credit, criminal, and rental histories.

- Collaborate with other systems serving people with barriers to housing, including substance use treatment, mental health, and homeless service systems, in state and local planning processes and on the statewide HIV/AIDS housing committee.
- Make accurate, up-to-date information regarding the needs of this population available to funders, elected officials, and other policy makers.

7. Develop a clearinghouse for information on housing assistance available to people living with HIV/AIDS that will be accessible to consumers and their advocates throughout the state.

- Information should at a minimum include resources dedicated to serving people living with HIV/AIDS.
- Information could be expanded to include all resources that are available to serve and/or house people with very low incomes.
- Information would need to be updated on a regular basis and distributed widely.

Key Findings of the Needs Assessment

The following findings indicate that there are many people living with HIV/AIDS in Indiana who have housing and related service needs that are not being met with current resources. These findings were reached through background research, surveys of and focus groups with people living with HIV/AIDS, and key informant interviews.

Research Findings

Background research was conducted during the needs assessment process to provide a framework for the subsequent discussion of HIV/AIDS housing issues. This research included a review of HIV/AIDS epidemiology, housing market information, homelessness data, income and poverty data, funding sources, and HIV/AIDS-dedicated housing programs.

The following information includes highlights from the research findings:

- As of June 30, 2002, there were a reported 3,368 people living with AIDS and another 3,668 people living with HIV who have not been diagnosed with AIDS. Since the epidemic began, 11,994 people have been diagnosed with HIV and/or AIDS in Indiana.
- Housing is unaffordable to many people living with HIV/AIDS. A person earning only Supplemental Security Income (SSI) can afford to pay just $164 per month in rent without incurring a cost burden, which is well below the Fair Market Rent (FMR) for a studio apartment ($321 in Putnam County and $384 in the Indianapolis EMSA).
- From June 2001 to July 2002 IHFA allocated $751,001 in HOPWA funds to 13 agencies in 11 regions of the state. Two-thirds of the funds were allocated to tenant-based or short-term rental assistance programs.

- From June 2001 to July 2002, the City of Indianapolis allocated $834,620 in HOPWA funds to 5 agencies in the Indianapolis metropolitan region (HIV Care Coordination Region 7).
- Each region of the state has some housing assistance that is dedicated to people living with HIV/AIDS. In total, there are 143 housing units and 190 tenant-based rental assistance vouchers, including 79 housing units and 71 vouchers in the Indianapolis EMSA.

Survey Findings

A housing survey was distributed to people living with HIV/AIDS throughout the state in order to gather more information about individuals' housing histories, needs, and preferences; 418 people living with HIV/AIDS completed surveys. At least ten completed surveys were received from people living with HIV/AIDS in each of the twelve HIV Care Coordination Regions.

The following themes emerged from survey respondents:

- Survey respondents had very low incomes. Respondents earned a median monthly income of $635; women and African Americans/Blacks earned less than $550 per month.
- Many survey respondents received some housing assistance, but most still pay a large portion of their income for housing. While 41 percent of respondents were receiving some type of housing assistance at the time of the survey, just 11 percent of respondents reported paying less than 30 percent of their income toward housing costs, the limit for affordability set by HUD.
- Consistent with the preferences expressed, the majority of respondents lived alone and rented their homes. In addition, 80 percent indicated they would rather pay more to live alone than share their housing with others.
- Behavioral health issues, such as mental health and substance use, affected a small but considerable percentage of people living with HIV/AIDS. Almost half of respondents had received mental health services and one in five had received substance use services in the past month.
- More than a third of respondents had experienced homelessness. The factors leading to homelessness reported most commonly by respondents were: no income from a job or benefits, a friend or family made them move, the respondent's use of alcohol or drugs, and eviction.

Focus Group Findings

People living with HIV/AIDS were solicited to participate in focus groups, and were provided compensation for doing so. Eight focus groups were held in seven of the twelve HIV Care Coordination Regions of the state: Region 1 (Gary), Region 2 (South Bend), Region 3 (Fort Wayne), Region 7 (Indianapolis), Region 9 (Richmond), Region 11 (Jeffersonville), and Region 12 (Evansville). Two focus groups were held in Region 7. A total of 64 people living with HIV/AIDS participated in the eight focus groups.

The people living with HIV/AIDS who participated in the focus groups had a wide variety of experiences and needs, as well as opinions about what housing and services would be helpful for people living with HIV/AIDS.

The following themes emerged from the focus groups:

- Participants identified affordability as their primary housing challenge. Many rely on support from families, Section 8, and HOPWA. In addition to affordability, barriers identified included poor credit, rental, and criminal histories.
- Participants were concerned about the quality of housing that is affordable to them. Primary concerns included physical quality of the units, landlords' unwilling to make repairs, and neighborhood safety.
- Participants expressed a desire to be independent. Generally, participants indicated a preference to live alone or with immediate family, to have housing integrated into the community, and to live close to businesses and services in order to be able to access them independently.
- Confidentiality was identified as critical to people living with HIV/AIDS as it affects their willingness to access services, including housing assistance. Most participants indicated an unwillingness to divulge their HIV status to their landlords and neighbors.
- Participants had many recommendations for HIV/AIDS housing and services. Access to legal services related to housing, as well as reliable sources of information about housing opportunities, were frequently cited.

Key Informant Interview Findings

Interviews were held with nearly 140 key informants from throughout the state. These community stakeholders were identified by Steering Committee members as those most knowledgeable about HIV/AIDS housing issues as well as able to provide leadership in the future on related issues. Key informants were interviewed from each of the twelve HIV Care Coordination Regions.

The following themes emerged from key informants and community meeting participants:

- There is a lack of housing that is affordable, decent, and safe for people who are living with HIV/AIDS and earn low incomes. In addition, many people face barriers to accessing housing, due to credit, criminal, and rental histories.
- Some people living with HIV/AIDS have multiple diagnoses that impact their housing stability, including substance use and mental health issues.
- Agencies are adapting to the changing populations in need of HIV/AIDS housing and services, including an increasing number of people of color and people leaving incarceration.
- HIV/AIDS service organizations throughout the state are generally well-connected with local social service and housing organizations at the level of service-provision, but few are actively participating in local housing planning processes and other forums for collaboration.
- Key informants discussed the administration and allocation of HOPWA funds statewide. Key informants expressed concerns about the group home model, described discrepancies between regions, and suggested that HOPWA be made available for housing development.
- Many key informants commented on the lack or limited availability of public transportation in some parts of the state and its impact on access to housing, services, and employment.
- Throughout the state, key informants indicated that the general population stigmatizes people living with HIV/AIDS which impacts their access to care, housing, services, and employment, as well as the support of their family, friends, and churches.

Introduction

The Indiana Housing Finance Authority, the City of Indianapolis, and The Damien Center contracted with AIDS Housing of Washington to facilitate this HIV/AIDS housing needs assessment and planning process. The needs assessment began in May 2002 and continued through February 2003.

The needs assessment process included: interviews with stakeholders, a consumer housing survey, focus groups with people living with HIV/AIDS, and a review of relevant planning and epidemiological data. A Steering Committee of Indiana stakeholders guided the process, interpreted findings, and developed critical issues and recommendations.

Background

The Indiana Housing Finance Authority (IHFA), the City of Indianapolis, and The Damien Center hired AIDS Housing of Washington (AHW) to facilitate a community-based needs assessment and planning process and to develop an HIV/AIDS housing plan. The planning process began in May 2002 and continued through February 2003.

AHW is a Seattle-based nonprofit organization that develops AIDS housing in the Seattle metropolitan area and provides technical assistance to agencies and communities nationwide. Federal funds were made available for this needs assessment by IHFA under the National Affordable Housing Act of 1990, as amended, using HOME Investment Partnership Program funds allocated by the U.S. Department of Housing and Urban Development (HUD). Funds for this project were also made available by the City of Indianapolis through HUD's Community Development Block Grant program, The Damien Center, and from AIDS Housing of Washington's National Technical Assistance Program.

Planning Process

Interested community members, including people living with HIV/AIDS, representatives of AIDS service and housing organizations, housing developers, members of local government agencies, advocates, and others participated in this planning effort. Relevant planning, housing, homelessness, and epidemiological data were reviewed and incorporated into the *Indiana HIV/AIDS Housing Plan*.

Community Participation

A Steering Committee was formed in June 2002 to oversee and guide the needs assessment and planning process. The committee was comprised of representatives from health, housing, and social service agencies and people living with HIV/AIDS from across the state. The Steering Committee identified critical issues and developed recommendations. Minutes from these meetings are provided in the appendices.

Key informant interviews were held with 140 people identified by the Steering Committee and other involved stakeholders. Group and individual interviews were conducted with case managers, housing and service providers, housing developers, government representatives, clinical social workers, and other concerned community members.[3] These stakeholders were identified as those most knowledgeable as well as able to provide leadership in the future on related issues.

A housing survey was distributed to people living with HIV/AIDS throughout the state in order to gather more information about individuals' housing histories, needs, and preferences. A total of 418 people living with HIV/AIDS completed surveys. Survey findings are presented in a chapter of the plan, and complete survey data appears in the appendices.

People living with HIV/AIDS were also included in the needs assessment process through focus groups. Focus groups allow for more qualitative and broader-ranging information than the survey. Focus groups were held in Gary, South Bend, Fort Wayne, Indianapolis, Richmond, Jeffersonville, and Evansville. A total of 64 people living with HIV/AIDS participated in one of the eight focus groups. Findings from the consumer focus groups are presented in a chapter of the plan, and summaries from each group appear in the appendices.

Review of Source Data

Data reviewed in the preparation of this plan includes information from the following documents:

- City of Indianapolis, *2002 Action Plan*, November 15, 2001.
- City of Indianapolis, *2002 Continuum of Care.*
- City of Indianapolis, *The 2000–2004 Consolidated Plan*, November 1999.
- Coalition for Homelessness Intervention and Prevention, *Blueprint to End Homelessness: An Initiative of the Indianapolis Housing Task Force*, April 18, 2002.
- Coalition for Homelessness Intervention and Prevention, *The Struggle to Stay Housed: Homelessness in Indianapolis, Statistics and Trends,* December 2001.
- Indiana Department of Commerce*, State of Indiana Consolidated Plan: 2001 Executive Summary*.
- Indiana Department of Commerce, *State of Indiana Consolidated Plan: 2002 5-Year Plan.*

Other information available on the Internet from the following organizations was also reviewed:

- Center on Budget and Policy Priorities
- Centers for Disease Control and Prevention
- National Alliance to End Homelessness
- U.S. Bureau of Economic Analysis
- U.S. Census Bureau
- U.S. Department of Housing and Urban Development
- U.S. Social Security Administration

[3] See the comprehensive list of key informants and agency affiliations at the front of this plan.

Data provided by the Indiana State Department of Health forms the basis for the epidemiological profile included in this report. Indiana's HIV Care Coordination Regions were used as the basis for geographical differentiation in the planning process. The counties in each HIV Care Coordination Region are presented in ***Table 1***.

Table 1:
Counties in Each HIV Care Coordination Region

HIV Care Coordination Region	Counties
Region 1	Lake, LaPorte, and Porter Counties. Lake and Porter Counties are a part of the Gary, Indiana Metropolitan Statistical Area (MSA).
Region 2	Elkhart, Fulton, Marshall, Pulaski, St. Joseph, and Starke Counties. St. Joseph County is part of the South Bend, Indiana MSA. Elkhart County is part of the Elkhart-Goshen, Indiana MSA.
Region 3	Adams, Allen, DeKalb, Huntington, Kosciusko, LaGrange, Noble, Steuben, Wabash, Wells, and Whitley Counties. Adams, Allen, DeKalb, Huntington, Wells, and Whitley Counties are part of the Fort Wayne, Indiana MSA.
Region 4	Benton, Carroll, Clinton, Fountain, Jasper, Montgomery, Newton, Tippecanoe, Warren, and White Counties. Clinton and Tippecanoe Counties are part of the Lafayette, Indiana MSA.
Region 5	Blackford, Delaware, Grant, Jay, and Randolph Counties. Delaware County is part of the Muncie, Indiana MSA.
Region 6	Cass, Hamilton, Hancock, Howard, Madison, Miami, and Tipton Counties. Hamilton, Hancock, and Madison Counties are part of the Indianapolis, Indiana MSA. Howard and Tipton Counties are part of the Kokomo, Indiana MSA.
Region 7	Boone, Hendricks, Johnson, Marion, Morgan, and Shelby Counties. All of Region 7 is part of the Indianapolis, Indiana MSA.
Region 8	Clay, Parke, Putnam, Sullivan, Vermillion, and Vigo Counties. Clay, Vermillion, and Vigo are part of the Terre Haute, Indiana MSA.
Region 9	Dearborn, Decatur, Fayette, Franklin, Henry, Ohio, Ripley, Rush, Union, and Wayne Counties. Dearborn County is part of the Cincinnati, Ohio–Kentucky–Indiana MSA. Ohio County is part of the Ohio County, Indiana MSA.
Region 10	Bartholomew, Brown, Greene, Lawrence, Monroe, and Owen Counties. Monroe County is part of the Bloomington, Indiana MSA.
Region 11	Clark, Crawford, Floyd, Harrison, Jackson, Jefferson, Jennings, Orange, Scott, Switzerland, and Washington Counties. Clark, Floyd, Harrison, and Scott Counties are part of the Louisville, Kentucky–Indiana MSA.
Region 12	Daviess, Dubois, Gibson, Knox, Martin, Perry, Pike, Posey, Spencer, Vanderburgh, and Warrick Counties. Posey, Vanderburgh, and Warrick Counties are part of the Evansville–Henderson, Indiana–Kentucky MSA.

HIV/AIDS Housing Plan

The *Indiana HIV/AIDS Housing Plan* provides a framework for assessing and planning for the housing needs of people living with HIV/AIDS. It represents the culmination of a yearlong effort by a broad cross section of concerned citizens to determine the housing needs of people living with HIV/AIDS and their families throughout the state.

The plan includes an overview of housing and homelessness issues, a demographic profile of individuals who are estimated to be living with HIV and AIDS, an overview of HIV/AIDS housing resources, a summary of consumer survey results, identification of critical issues, and recommendations.

Given the dynamic nature of HIV disease and other factors that affect HIV/AIDS housing planning, it is essential to regularly reassess the needs of people living with HIV/AIDS and the most appropriate strategies to meet those needs. It is intended that this plan be built upon, revised, and expanded as current objectives are met and new gaps and needs emerge.

The Context of HIV/AIDS Housing in the United States

Limited federal funding, the pervasive lack of affordable housing, the expanding number of people living with HIV/AIDS, and advances in AIDS treatment protocols all impact the planning for, and the provision of, AIDS housing and support services. The following pages outline the context of HIV/AIDS housing in 2002.

A Brief History of AIDS Housing

In the last twenty years, AIDS housing has developed to meet the housing and support service needs of people living with HIV/AIDS. The fluctuating nature of the disease makes support services—case management, at a minimum, as well as access to community-based medical services—a necessary component of all types and models of residential programs, whether provided on- or off-site.

The earliest AIDS housing projects were developed in the mid-1980s in the communities first affected by HIV/AIDS, including New York, San Francisco, and Los Angeles. At that time, no specific funding dedicated for AIDS housing existed, and the projects were developed with funding from concerned individuals, faith-based communities, local organizations, and occasional local government funds, along with hours of volunteer labor. Many of these initial projects were small facilities providing hospice care or group homes. All relied on volunteers to supplement few, if any, paid staff.

In the 1990s, much of the development and provision of AIDS housing shifted to mainstream affordable and supportive housing providers, as well as public housing authorities and local governments. The first phase of a national AIDS housing cost study, completed in 1999 by Vanderbilt University, found that nearly 28,000 units of housing in the U.S. are dedicated for people living with HIV/AIDS. Most of these units (17,190) are provided through the use of vouchers, integrating people living with HIV/AIDS into the mainstream community.[4] Today, virtually every AIDS housing project receives government funding, and has paid staff, written operating policies, and a more defined role within a continuum of housing.

Funding for HIV/AIDS Housing and Services

Since 1992, when the Housing Opportunities for Persons with AIDS (HOPWA) program was first authorized, the federal government has made available more than $1.7 billion in HOPWA funds to support community efforts to create and operate HIV/AIDS housing and provide related services.[5] Starting in 1992, there were 27 eligible metropolitan statistical areas (EMSAs) and 11 states eligible to receive formula allocations of $42.9 million in HOPWA funds. By FY 2002, $257 million in

[4] Debra Rog, and Sidra Goldwater, *The Landscape of AIDS Housing*, Vanderbilt University, Washington, DC, 1999.
[5] U.S. Department of Housing and Urban Development, Housing Opportunities for Persons with AIDS (HOPWA). Available online: www.hud.gov/offices/cpd/aidshousing/programs/index.cfm (Accessed: October 14, 2002).

HOPWA funds was available for formula allocations and competitive awards. A total of 108 jurisdictions—74 metropolitan areas and 34 states—received formula allocations in 2002.[6]

The other major federal program providing funding dedicated for people living with HIV/AIDS is the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, which is administered by the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA). The Ryan White CARE Act was reauthorized in 2000. In FY 2001, $1.8 billion was appropriated for use under the Ryan White CARE Act.

Many AIDS housing and service providers rely on funding from Ryan White and HOPWA to support their programs. The first phase of the AIDS housing cost study referenced above determined that 66 percent of the nation's AIDS housing providers received HOPWA funding for AIDS housing and services, while 55 percent received Ryan White funds. These two funding sources are extremely important to the ability of these agencies to provide AIDS housing and are often used in tandem—44 percent of AIDS housing providers indicated that they receive funding from both HOPWA and Ryan White.[7]

While the number of people living with HIV/AIDS continues to increase, funding for HOPWA and other federal and state housing programs remains under budgetary pressure. More individuals are eligible for and in need of services, and communities are faced with the challenge of utilizing limited resources to meet multiple needs.

Affordable Housing

In addition to the funding concerns particular to HIV/AIDS housing and services, there is a crisis in affordable housing in the United States. Unprecedented economic growth has not raised all incomes equally, although it has raised housing costs. The Joint Center for Housing Studies of Harvard University reported that 14 million American households were spending more than half of their incomes for housing in 1999, and 2 million households were living in homes with serious structural problems.[8] In 2001, there were no states where a full-time, minimum-wage worker could afford a 2-bedroom apartment renting at or above the federally established Fair Market Rent.[9] Clearly, people with disabilities depending on Supplemental Security Income (SSI)—equivalent to just 60 percent of federal minimum wage in 2002—have even fewer housing choices.

[6] U.S. Department of Housing and Urban Development, Office of HIV/AIDS Housing, *Housing Opportunities for Persons with AIDS,* Fact Sheet. Available online: www.hud.gov/offices/cpd/aidshousing/pdf/factsheet.pdf (Accessed: October 14, 2002).
[7] Ibid.
[8] Joint Center for Housing Studies of Harvard University, *The State of the Nation's Housing: 2001*, June 2001, p. 3. Available online: www.gsd.harvard.edu/jcenter (Accessed: January 9, 2002).
[9] Ibid, p. 22.

Complexity of Lives

Homelessness, mental illness, substance use issues, and incarceration are increasingly issues in the lives of people living with HIV/AIDS, and impact both housing needs of people living with HIV/AIDS, and the work of AIDS housing providers.

The housing affordability crisis in the United States has been a driving factor for a burgeoning homeless population. It is estimated that on any given night, 750,000 Americans are homeless, and as many as 2 million are homeless at some point each year.[10] The U.S. homeless population has an estimated median rate of HIV prevalence at least three times higher—3.4 percent versus 1 percent—than the general population.[11] Among more than 5,000 people living with HIV/AIDS surveyed by AIDS Housing of Washington in 23 areas around the country since 1993, 41 percent indicated they had been homeless at some point in their lives.[12]

Increasingly, people living with HIV/AIDS also have mental health or substance use issues that may or may not be combined with homelessness. Thirty-seven percent of people living with HIV/AIDS surveyed by AIDS Housing of Washington reported being disabled by mental illness and 37 percent reported a disability related to substance use issues.[13]

Substance use and homelessness are also closely associated with incarceration and involvement with the criminal justice system. Particularly as people living with HIV/AIDS live longer lives, incarceration is an issue for a growing number of people living with HIV/AIDS. Almost one-quarter of all people infected with HIV were released from prison or jail in 1999.[14] Having a criminal history can make a person ineligible for many types of housing and services, as well as limit employment opportunities.

Appropriate services and housing for people with histories of homelessness, mental illness, substance use, and/or incarceration can make a critical difference in improving health and quality of life. For example, housing stability is often necessary for a person living with HIV/AIDS to gain access to health care and adhere to treatment regimens. Individuals who have had histories of substance use, mental illness, and homelessness often need ongoing support services in order to maintain stable housing. People affected by these issues may need job skills training and ongoing support in order to obtain and maintain employment.

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[10] National Alliance to End Homelessness, *Facts About Homelessness.* Available online: www.naeh.org/back/factsus.htm (Accessed: January 10, 2002).

[11] Higher rates (8.5 to 62 percent) have been found in selected homeless sub-populations. John Song, M.D., M.P.H., M.A.T., *HIV/AIDS & Homelessness: Recommendations for Clinical Practice and Public Policy,* National Health Care for the Homeless Council, Health Care for the Homeless Clinician's Network, November 1999, p. 1. Available online: www.nhchc.org (Accessed: January 10, 2002).

[12] AIDS Housing of Washington, *Fact Sheet: AIDS Housing Survey*. Available online: www.aidshousing.org/ahw_library2275/ahw_library_show.htm?doc_id=76974 (Accessed: January 10, 2002). Areas represented are: Alameda County, Atlanta, Chicago, Contra Costa County, Dallas, Fresno County, Kentucky, Maryland, Orange County, Philadelphia, Phoenix, Pittsburgh, Portland, Oregon, Riverside/San Bernardino Counties, San Diego County, Snohomish County, WA, Utah, Washington, DC, and Washington State, between 1993 and 2000.

[13] Ibid.

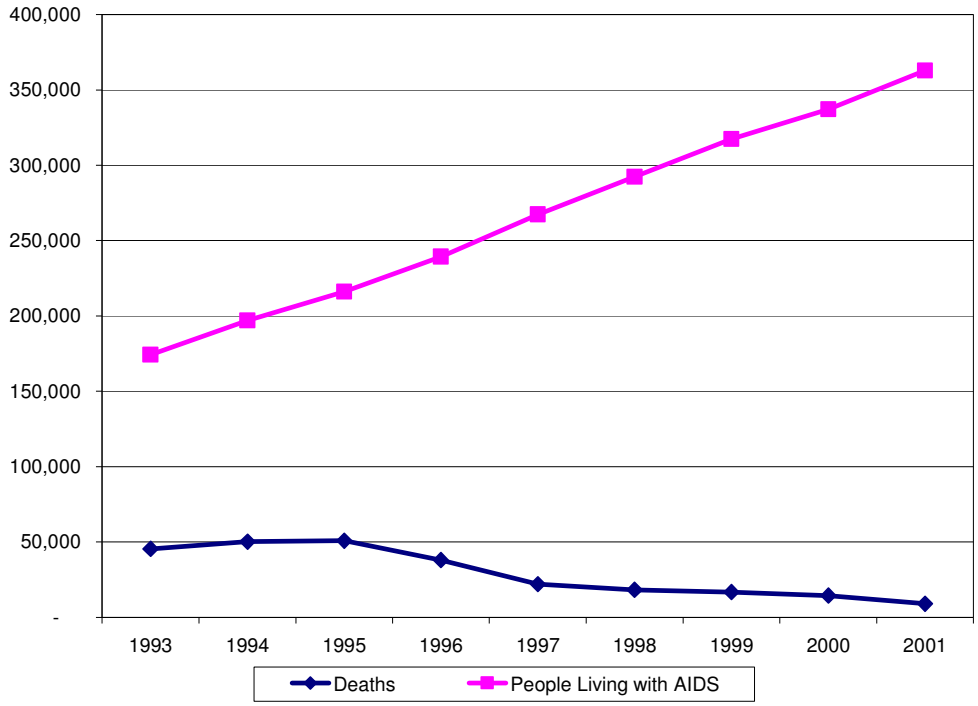
[14] Unpublished study by Theodore Hammett, PhD, Abt Associates. Cited in Fox Butterfield, "Getting Out: A Special Report; Often, Parole is One Stop on the Way Back to Prison," *The New York Times*, November 29, 2000.

Providing the level of support that many of these individuals need in order to maintain their housing and income is very expensive. However, a recent study found that supportive housing for people with mental illness actually saved more than $16,000 per person per year in public funds due to the reduced costs of hospitalizations, incarceration, and shelter.[15] Still, demands on all of the systems serving people living with HIV/AIDS are increasing, and resources for meeting identified needs are not expected to increase significantly in the future.

Trends in the Epidemiology of HIV/AIDS in the United States

The number of new AIDS cases diagnosed in the United States each year has decreased steadily since 1993.[16] At the same time, medical advances in the treatment of HIV have dramatically slowed the death rates of people living with HIV. As a result, more people are now living with AIDS in the United States than ever before. ***Figure 1*** shows the number of people living with AIDS and the number of AIDS deaths from 1993 through 2001.

Figure 1:
People Living with AIDS and Rate of Deaths, 1993-2001



Source: Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Division of HIV/STD Prevention. *HIV/AIDS Surveillance Report. Year-end 2001.* Vol. 13, No. 2. Tables 27, 31. Available online: www.cdc.gov/hiv/stats/hasr1202.htm (Accessed: November 18, 2002).

[15] Ted Houghton, *The New York/New York Agreement Cost Study: The Impact of Supportive Housing on Services Use for Homeless Mentally Ill Individuals*, Corporation for Supportive Housing, New York, 2001. Available online: www.csh.org/NYNYSummary.pdf (Accessed: January 10, 2002).

[16] Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Divisions of HIV/AIDS Prevention, *HIV/AIDS Surveillance Reports*, Years-end 1993–1999, Mid-year 2000. Available online: www.cdc.gov/hiv/stats/hasrlink.htm (Accessed: January 10, 2002).

While the HIV/AIDS epidemic originated in the larger metropolitan areas of the United States, every state reported new AIDS cases diagnosed in 2000[17] and about 6 percent of the AIDS cases reported in 1999 were from rural areas.[18] The gender, racial/ethnic, and age profiles of people living with HIV/AIDS have also shifted over the course of the epidemic:

- The proportion of new AIDS cases reported among adult and adolescent women more than tripled over a fifteen-year period, from 7 percent of cases reported in 1985 to 25 percent in 2000.[19]
- African American and Latina women together represent less than one-quarter of all U.S. women, yet they account for more than three-quarters (78 percent) of AIDS cases reported to date among women in this country.[20]
- African Americans represented 38 pecent of the AIDS cases reported in 2000,[21] but are just 12 percent of the U.S. population.[22]
- It is estimated that at least half of all new HIV infections in the U.S. are among people under 25, and the majority of HIV infections among young people are transmitted sexually.[23]

Medical Advances in Treating People Living with HIV/AIDS

People living with HIV/AIDS who are being successfully treated with Highly Active Anti-Retroviral Therapy (HAART)—often referred to as combination therapies or the "cocktail"—are experiencing significant improvements in health. Many people living with HIV/AIDS are considering reemployment and evaluating the impact that returning to work could have on their disability and medical benefits.

However, even individuals who have access to these medications, who are closely monitored, and who have their medications adjusted as frequently as every three months, are experiencing failure. There is now a growing consensus that continuous HAART therapy is not a viable option, even for those who experience some health improvements, due to the severity of short- and long-term side effects.[24] Additionally, a study released at the end of 2001—the first large-scale study of drug resistance—found that half of people living with AIDS had a strain of HIV that was resistant to at least one drug used to treat HIV. It also found that 20 percent of people infected in 2000 had a drug-

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[17] Ibid, Table 2.

[18] Joan Stephenson, PhD, "Rural HIV/AIDS in the United States: Studies Suggest Presence, No Rampant Spread," *Journal of the American Medical Association*, Vol. 284, No. 2, July 12, 2000. Available online: jama.ama-assn.org/issues/v284n2/ffull/jmn0712-2.html (Accessed: January 10, 2002).

[19] Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Divisions of HIV/AIDS Prevention, "HIV/AIDS Among U.S. Women: Minority and Young Women at Continuing Risk," Fact Sheet. Available online: www.cdc.gov/hiv/pubs/facts/women.htm (Accessed: January 10, 2002). Updated with AHW tabulations using data from: Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Divisions of HIV/STD Prevention, *HIV/AIDS Surveillance Report, Year-end 2000*, Vol. 12, No. 2, Table 5. Available online: www.cdc.gov/hiv/stats/hasr1202.htm (Accessed: January 10, 2002).

[20] Ibid.

[21] Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Divisions of HIV/AIDS Prevention, *HIV/AIDS Surveillance Report, Year-end 2000,* Vol. 12, No. 2, Table 7. Available online: www.cdc.gov/hiv/stats/hasr1202/table7.htm (Accessed: January 9, 2002).

[22] U.S. Census Bureau, *DP-1: Profile of General Demographic Characteristics: 2000,* Data set: Census 2000 Summary File 1 (SF 1) 100-Percent Data. Available online: factfinder.census.gov/home/en/sf1.html (Accessed: January 9, 2002).

[23] Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Divisions of HIV/AIDS Prevention, *Young People at Risk: HIV/AIDS Among America's Youth.* Available online: www.cdc.gov/hiv/pubs/facts/youth.htm (Accessed: January 10, 2002).

[24] Anthony Fauci, MD, of the National Institute of Allergy and Infectious Disease. Quoted in Lark Lands, "Treatment: Stop + Start," *POZ,* October 2000.

resistant strain. These findings suggest that a growing number of people living with HIV/AIDS have strains that are becoming difficult to treat with existing drugs, and that more people are infected at the outset with resistant strains.[25]

Not all people living with HIV/AIDS who might be helped by existing HIV treatments necessarily have access to them. The medications and monitoring associated with HAART are expensive—$10,000 to $15,000 each year—putting them well out of reach for people who do not have adequate insurance or access to state-run AIDS Drug Assistance Programs. Studies show persisting disparities in access to these medications, particularly among women, people of color, and injection drug users.[26] Another study published in 2001 estimated that nearly all of the 750,000 people living with HIV in the United States would have met the criteria for being offered HAART, but that only about 200,000 were using it.[27]

Sustaining AIDS Housing

The focus of AIDS housing providers has shifted from helping people at the end of their lives to helping them transition to living with HIV and AIDS. AIDS housing providers are seeing more and more clients with histories of homelessness, mental illness, and/or substance use, with HIV often secondary or tertiary among a client's concerns. Measurements of success for tenants are more complex: positive outcomes range from housing stability, improved health status, and sobriety, to decreasing use of nonprescription drugs and gaining life skills that may lead to employment.

Unlike the informal arrangements that characterized its early years, AIDS housing now is typically based on long-term contractual relationships, tenants' ability to pay rent and meet lease requirements, and providers' community-wide collaborations and multiple funding sources. Providers have not only had to learn to operate permanent housing within the context of landlord-tenant laws, but also to gain a high degree of sophistication in accessing a range of state and local funding sources and partnering with mainstream housing and social service agencies.

Providers outside of metropolitan areas, especially in the scattered towns of rural America, have their own challenges, including transportation to care, minimal community knowledge of the disease, and a lack of rental housing units. Rural AIDS housing providers are also often constrained by their own lack of experience in housing, few partnering or collaborative opportunities, and limited funding opportunities. They have had to learn to innovate and stretch their dollars any way they can to serve their growing client base.

While the AIDS housing community's goal of meeting the housing needs of people living with HIV and AIDS has not changed, the AIDS service and housing world has changed dramatically. The challenge for AIDS housing providers is to ensure that resources will be available to clients over the long term, and to find the balance between flexibility and stability.

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[25] David Brown, "Study Finds Drug-Resistant HIV in Half of Infected Patients," *Washington Post*, Wednesday, December 19, 2001, p. A2.

[26] Usha Sambamoorthi, PhD, et al. "Use of Protease Inhibitors and Non-Nucleoside Reverse Transcriptase Inhibitors Among Medicaid Beneficiaries with AIDS," *American Journal of Public Health*, September 2001, Vol. 91, No. 9, pp. 1474-1481. Available online: www.ajph.org/cgi/reprint/91/9/1474.pdf (Accessed January 10, 2002).

[27] James G. Kahn, MD, MPH, Brian Halle, MPP, MA, Jennifer Kates, MPA, MA, and Sophia Chang, MD, MPH, "Health and Federal Budgetary Effects of Increasing Access to Antiretroviral Medications for HIV by Expanding Medicaid," *American Journal of Public Health*, September 2001, Vol. 91, No. 9, pp. 1464-1473. Available online: www.ajph.org/cgi/reprint/91/9/1464.pdf (Accessed: January 10, 2002).

HIV/AIDS in Indiana

Since the epidemic began, 11,994 people have been diagnosed with HIV and/or AIDS in Indiana. Advances in medical treatment combined with continuing new infections mean more people are now living with HIV and AIDS than ever before. As of June 30, 2002, there were a reported 3,368 people living with AIDS and another 3,668 people living with HIV who have not been diagnosed with AIDS.

In order to assess and plan for housing and services for people living with HIV/AIDS, it is important to have background information on the populations living with HIV/AIDS. This chapter of the plan presents HIV/AIDS epidemiology data from the Centers for Disease Control and Prevention and the Indiana State Department of Health. The HIV Disease Surveillance Program of the Department of Health provided data upon request from AIDS Housing of Washington.

Three types of HIV/AIDS data are presented. First, cumulative case data reflects all reported cases since the epidemic began. In Indiana, AIDS reporting started in 1986 and HIV reporting started in 1988. People reflected in cumulative case data may now be living or deceased. Second, living case data reflects the people who were living with HIV or AIDS at a point in time. Because this plan addresses the housing and service needs of people living with HIV or AIDS, living case data is significant. Third, incidence rates put the number of people reported with HIV or AIDS in a geographic area in terms of a rate per population. Numbers of cases are typically described in terms of number per 100,000 people. This allows for comparisons between geographic areas of different size during an established period of time.

State-level data and data for Indiana's twelve HIV Care Coordination Regions are presented in this chapter. More detailed data, by county, is available in ***Appendices 1 through 12.*** The counties included in each HIV Care Coordination Region are listed in the "Introduction" section of the plan.

Key Findings

People are living with HIV and AIDS in each of the twelve HIV Care Coordination Regions. At least 240 cumulative cases of HIV and AIDS have been reported in each region since reporting began in 1986, and at least 100 people are living with HIV/AIDS in each region of the state, underscoring the importance of federal, state, and local funding and programs serving this population.

Some regions of the state have been impacted by the HIV virus more than others. For example, the Indianapolis region accounts for 20 percent of the state's population but more than 40 percent of the state's cumulative reported HIV/AIDS cases. Region 1 (Gary) has also been greatly impacted, while other regions, such as Region 3 (Fort Wayne), account for a smaller percentage of the state's cumulative reported HIV/AIDS cases than of the state's population.

HIV/AIDS in the United States

The Centers for Disease Control and Prevention estimated 338,978 people living with AIDS in the United States at the end of 2000, the most recent year for which an estimate is available. Of these, African Americans/Blacks were the largest group, at 41 percent. Whites/Caucasians were the second largest group, at 38 percent, and Hispanics/Latinos were the third largest, at 20 percent. Seventy-eight percent of those living with AIDS were men.[28]

In June 2001, another 134,505 people in the United States were known to be living with HIV and not diagnosed with AIDS.[29] Unduplicated HIV statistics are not available from every state and many people who are living with HIV may not have been tested at all. The CDC estimates that between 800,000 and 900,000 Americans are living with HIV/AIDS, and that another 40,000 become infected every year.[30]

HIV/AIDS in Indiana

Among the 50 states, Indiana ranked 32nd with an annual case rate of 6 per 100,000 people (July 2000 to June 2001). In comparison, Washington, DC had 166 cases per 100,000 people, Florida had 32 cases, Michigan had 8 cases, Kentucky had 7 cases, and Ohio had 5 cases.[31]

According to the Indiana State Department of Health, 318 new HIV and AIDS cases were reported in Indiana between January and June 2001, while 560 cases were reported between January and June 2002. However, this increase does not necessarily indicate a rise in the incidence of HIV disease or its diagnosis.[32]

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[28] Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Divisions of HIV/STD Prevention, *HIV/AIDS Surveillance Report, Mid-year 2001*, Vol. 13, No. 1, Tables 26–27.

[29] Ibid, Table 1. Persons reported to be living with HIV infection and with AIDS, by area and age group.

[30] Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Divisions of HIV/AIDS Prevention, *A Glance at the HIV Epidemic,* December 2000. Available online: www.cdc.gov/nchstp/od/news/At-a-Glance.pdf (Accessed: August 30, 2002).

[31] Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Divisions of HIV/STD Prevention, *HIV/AIDS Surveillance Report, Mid-year 2001*, Vol. 13, No. 1, Tables 2.

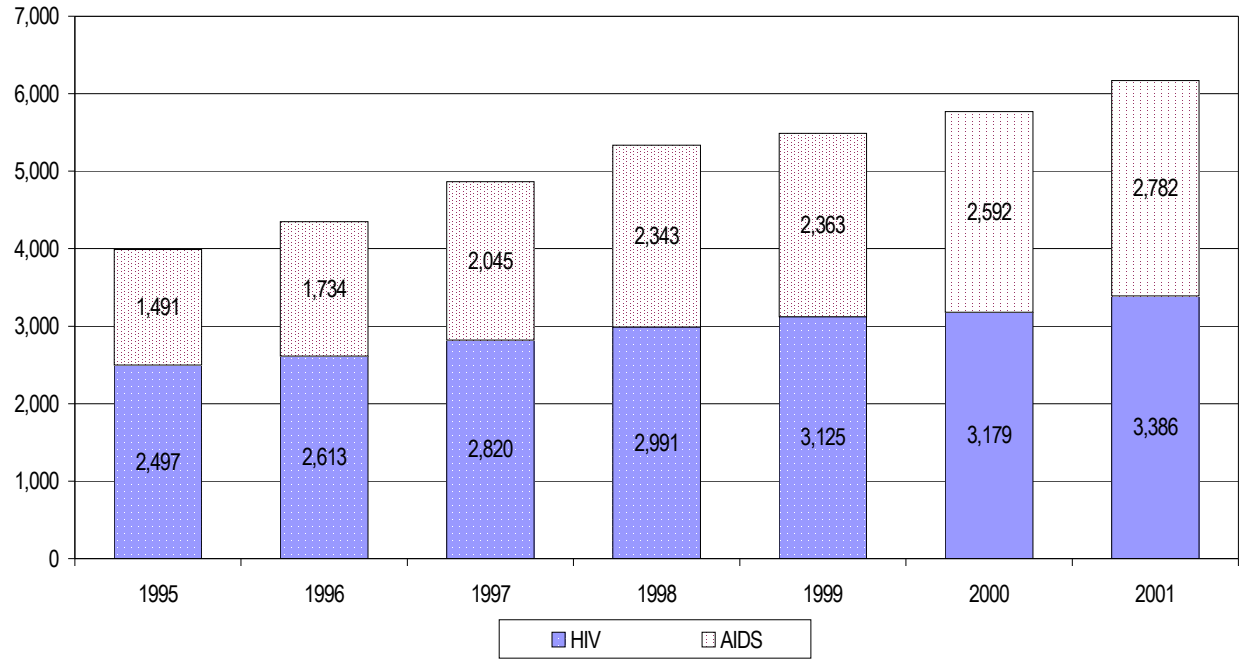
[32] Indiana State Department of Health, *Increase in HIV/AIDS Reports in First Six Months of 2002.* Available online: http://www.in.gov/isdh/programs/hivstd/quarterly/2002/june/currently.htm#Increase (Accessed: August 30, 2002). During this time frame, the dates of initial diagnosis for these patients spanned 1985 to 2002. Each diagnosis was reported within a week of diagnosis and by each physician from each hospital that saw the patient. Each related laboratory finding was also reported. Other reporting requirements also apply. Many entities came together in 2002 to allow many previously unreported cases to be reported. Many organizations, facilities, programs, hospitals, physicians, nurse practitioners, infection control practitioners, and others worked diligently to identify the unreported cases in order to better describe the impact of HIV disease in Indiana. The result is a slight increase in the proportion of some previously underreported groups. The first obvious increase is in the number of people who were initially diagnosed in another state and have since then moved to Indiana. This increases the prevalence of HIV disease that is reported to the Centers for Disease Control and Prevention (CDC). These patients have been and are receiving medical and social services in Indiana. It is critical to report each diagnosis of this disease for program planning, program evaluation, and federal funding for all HIV/AIDS-related programs. The proportional increases in reported cases in 2002 were among males, Whites/Caucasians, White/Caucasian males, Hispanic/Latino females, men who have sex with men, and those of a younger age.

People Living with HIV/AIDS

Medical advances that can prolong the lives of people living with HIV/AIDS, combined with continuing new infections, mean that more people are living with HIV/AIDS in Indiana than ever before.

Figure 2 presents living HIV and AIDS case data from several years of reports from the Centers for Disease Control and Prevention.

Figure 2:
People Living with HIV and AIDS in Indiana, June 1995 to June 2001



Source: Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Divisions of HIV/STD Prevention, *HIV/AIDS Surveillance Reports, Mid-year 1995–2001,* Vols. 7-12, No. 2. Available online: www.cdc.gov/hiv/stats/hasrlink.HTM (Accessed: September 5, 2002).

Table 2 presents the number and percent of people living with HIV (without an AIDS diagnosis) and with AIDS, by HIV Care Coordination Region.

Table 2:
People Living with HIV and AIDS in Indiana, by HIV Care Coordination Region, as of June 30, 2002

HIV Care Coordination Region (Major City)	Living HIV Cases (no AIDS diagnosis)		Living AIDS Cases	
	Number	Percent	Number	Percent
Region 1 (Gary)	582	16%	463	14%
Region 2 (South Bend)	250	7%	224	7%
Region 3 (Fort Wayne)	240	7%	218	6%
Region 4 (Lafayette)	79	2%	73	2%
Region 5 (Muncie)	97	3%	94	3%
Region 6 (Anderson)	189	5%	206	6%
Region 7 (Indianapolis)	1,614	44%	1,482	44%
Region 8 (Terre Haute)	132	4%	127	4%
Region 9 (Richmond)	49	1%	75	2%
Region 10 (Bloomington)	121	3%	126	4%
Region 11 (Jeffersonville)	129	4%	131	4%
Region 12 (Evansville)	186	5%	149	4%
Indiana	**3,668**	**100%**	**3,368**	**100%**

Source: Indiana State Department of Health, HIV Surveillance Program, email communication, August 20, 2002.

Region 1 (Gary) and Region 7 (Indianapolis) account for nearly 60 percent of people living with HIV and AIDS in Indiana. However, people are living with HIV and AIDS in each of the twelve HIV Care Coordination Regions throughout the state of Indiana. At least 240 cumulative cases of HIV and AIDS and at least 124 people living with HIV and AIDS have been reported in each region since reporting began in 1986.

Table 3 presents race/ethnicity, gender, age at diagnosis, and transmission category data for people living with HIV (without an AIDS diagnosis) and with AIDS.

Table 3:
People Living with HIV and AIDS Cases in Indiana, by Race/Ethnicity, Gender, Age at Diagnosis, and Transmission Category, as of June 30, 2002

Demographics	Living HIV Cases (no AIDS diagnosis)		Living AIDS Cases	
	Number	**Percent**	**Number**	**Percent**
Race/Ethnicity				
White/Caucasian	2,169	59%	2168	64%
African American/Black	1,314	36%	1023	30%
Hispanic/Latino	158	4%	162	5%
Asian/Pacific Islander	18	1%	8	<1%
American Indian/Alaska Native	9	<1%	7	<1%
Total	**3,668**	**100%**	**3,368**	**100%**
Gender				
Male	2,927	80%	2,901	86%
Female	741	20%	467	14%
Total	**3,668**	**100%**	**3,368**	**100%**
Age at Diagnosis				
0-19	52	1%	36	1%
20-29	532	15%	180	5%
30-39	1,522	42%	1,235	37%
40-49	1,156	32%	1,361	40%
50 and older	406	11%	556	17%
Total	**3,668**	**100%**	**3,368**	**100%**
Transmission Category				
Men who have sex with men (MSM)	1,819	50%	1,940	58%
Injection Drug Use (IDU)	350	10%	378	11%
MSM/IDU	172	5%	212	6%
Heterosexual contact with HIV+	591	16%	428	13%
Transplant or Coagulation Disorder	32	1%	53	2%
Mother with/at risk for HIV infection	31	1%	28	1%
Not reported/other	673	18%	329	10%
Total	**3,668**	**100%**	**3,368**	**100%**

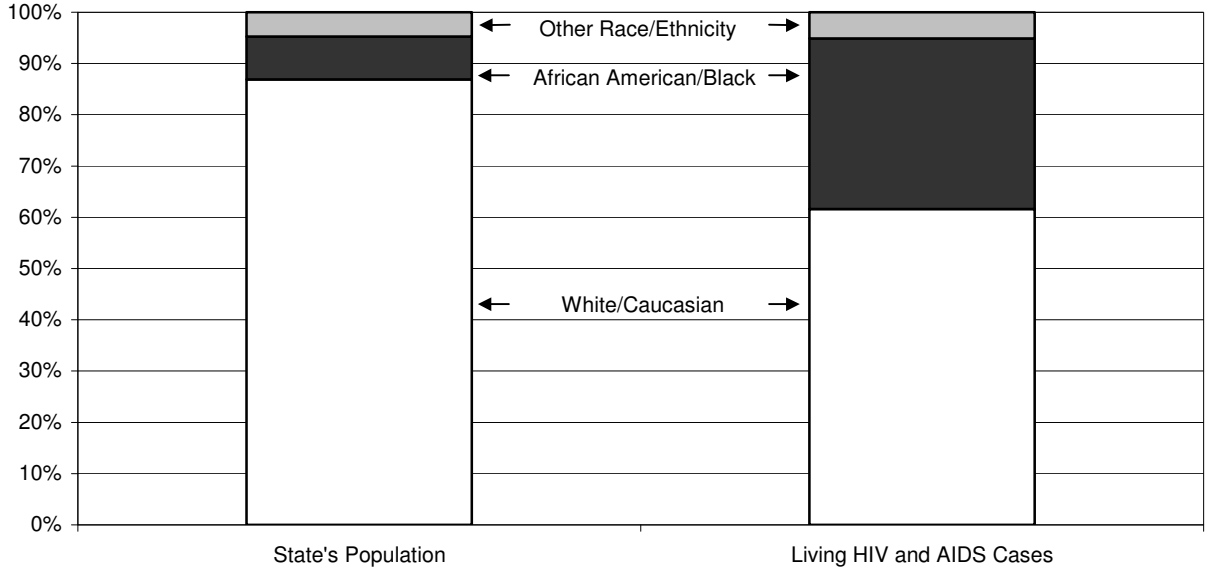
Source: Indiana State Department of Health, HIV Surveillance Program, email communication, August 20, 2002.

Compared to cases of people living with AIDS, people living with HIV are more likely to be African American/Black, female, 20 to 29 years old at first diagnosis, or to have acquired the disease through heterosexual contact. These differences may indicate that education and prevention efforts need to target people who are younger, of color, female, and who acquired the disease heterosexually.

There are some regional differences in the demographic profile of people living with HIV and AIDS in Indiana. For example, more than 23 percent of people living with HIV in Region 5 (Muncie) and Region 6 (Anderson) acquired the disease through heterosexual contact, compared to 16 percent for the state. Three regions had much higher percentages of people acquiring the disease through injection drug use (IDU) than the rest of the state: among people living with AIDS in Region 1 (Gary), Region 8 (Terre Haute), and Region 11 (Jeffersonville), more than 15 percent acquired the disease through IDU, compared to 10 percent for the state. Twenty-two percent of those living with HIV in Region 2 (South Bend) were diagnosed with HIV during their 20s, compared to 15 percent for the state.

Figure 3 demonstrates that African Americans/Blacks comprise a much higher percentage of people living with HIV and AIDS than of the total population in Indiana.

Figure 3:
Race/Ethnicity of Indiana Total Population (2000) and People Living With HIV and AIDS, as of June 30, 2002



Sources: Indiana State Department of Health, HIV Surveillance Program, email communication, August 20, 2002, and U.S. Census Bureau, *GCT-PL, Race and Hispanic or Latino*. Available online: factfinder.census.gov/servlet/BasicFactsServlet (Accessed online: August 20, 2002).

While White/Caucasian residents of Indiana account for 87 percent of the state's population, only 62 percent of the state's residents living with HIV and AIDS are White/Caucasian. Meanwhile, African Americans/Blacks comprise only 8 percent of the state's population, yet account for one-third of residents living with HIV and AIDS. People of other races account for 5 percent of the state's population and 5 percent of people living with HIV and AIDS.[33]

Region 1 (Gary) is the only region in the state with more cumulative reported HIV and AIDS cases and living HIV and AIDS cases among African Americans/Blacks than Whites/Caucasians. African Americans/Blacks account for 18 percent of the total population of Region 1 and over 50 percent of residents living with HIV and AIDS.

Cumulative Reported HIV/AIDS Cases

Table 4 presents population and cumulative HIV and AIDS cases in Indiana, by HIV Care Coordination Region. Cumulative case data represents people living and people who are deceased.

Table 4:
Total Population (2000) and Cumulative HIV/AIDS Cases in Indiana, by HIV Care Coordination Region, as of June 30, 2002

HIV Care Coordination Region (Major City)	Population	Percent of State Population	Cumulative HIV and AIDS Cases	Percent of State Cumulative HIV and AIDS Cases
Region 1 (Gary)	741,468	12%	1,887	16%
Region 2 (South Bend)	551,300	9%	841	7%
Region 3 (Fort Wayne)	725,556	12%	836	7%
Region 4 (Lafayette)	346,285	6%	290	2%
Region 5 (Muncie)	255,427	4%	326	3%
Region 6 (Anderson)	550,042	9%	648	5%
Region 7 (Indianapolis)	1,235,997	20%	4,913	41%
Region 8 (Terre Haute)	224,203	4%	462	4%
Region 9 (Richmond)	295,764	5%	240	2%
Region 10 (Bloomington)	307,820	5%	422	4%
Region 11 (Jeffersonville)	391,511	6%	455	4%
Region 12 (Evansville)	455,112	7%	674	6%
Indiana	**6,080,485**	**100%**	**11,994**	**100%**

Source: Indiana State Department of Health, HIV Surveillance Program, email communication, August 20, 2002, and U.S. Census Bureau, *GCT-PL, Race and Hispanic or Latino 2000.* Available online: factfinder.census.gov/servlet/BasicFactsServlet (Accessed online: January 31, 2002).

[33] U.S. Census Bureau, *GCT-PL, Race and Hispanic or Latino*. Available online: factfinder.census.gov/servlet/BasicFactsServlet (Accessed online: August 20, 2002).

While each region of Indiana has been impacted by HIV, Table 1 demonstrates that some regions have been disproportionately impacted. Region 1 (Gary) and Region 7 (Indianapolis), the two most populous and urban regions of the state, account for a larger percentage of the state's cumulative reported HIV and AIDS cases (16 percent and 41 percent, respectively) than of the state's total population (12 percent and 20 percent, respectively).

Conversely, Region 3 (Fort Wayne), the third most populous region in the state, has a smaller percentage of the state's cumulative reported HIV and AIDS cases (7 percent) than its percentage of the state's population (12 percent), as do eight other regions. Region 8 (Terre Haute) has 4 percent of the state's population and 4 percent of the state's cumulative reported HIV and AIDS cases.

Table 5 presents cumulative HIV and AIDS case data in a demographic profile as of June 30, 2002.

Table 5:
Cumulative HIV and AIDS Cases in Indiana, by Race/Ethnicity, Gender, Age at Diagnosis, and Transmission Category, as of June 30, 2002

Demographics	Cumulative HIV and AIDS Cases	
	Number	**Percent**
Race/Ethnicity		
White/Caucasian	7,967	66%
African American/Black	3,540	30%
Hispanic/Latino	432	4%
Asian/Pacific Islander	33	<1%
American Indian/Alaska Native	22	<1%
Total	**11,994**	**100%**
Gender		
Male	10,317	86%
Female	1,677	14%
Total	**11,994**	**100%**
Age at Diagnosis		
Unknown	41	<1%
0-19	397	3%
20-29	3,671	31%
30-39	5,033	42%
40-49	2,058	17%
50 and older	794	6%
Total	**11,994**	**100%**
Transmission Category		
Men who have sex with men (MSM)	6,793	57%
Injection Drug Use (IDU)	1,251	10%
MSM/IDU	733	6%
Heterosexual contact with HIV+	1,333	11%
Transplant or Coagulation Disorder	257	2%
Mother with/at risk for HIV infection	80	1%
Not reported/other	1,547	13%
Total	**11,994**	**100%**

Source: Indiana State Department of Health, HIV Surveillance Program, email communication, August 20, 2002.

Income, Housing Affordability, and Homelessness

The following pages present information about income, poverty, housing, and homelessness in Indiana in general. Findings from prior housing and homelessness planning conducted in the state are also included.

Housing market trends in Indiana affect people living with HIV/AIDS just as they affect other people. The following pages present information related to Indiana's housing market, housing affordability, and homelessness that are not necessarily specific to people living with HIV/AIDS.

Income and Poverty

Every year, the U.S. Department of Housing and Urban Development (HUD) estimates a Median Family Income (MFI) for use with the Section 8 program. MFIs are set for metropolitan areas and counties, as well as at the state level. HUD updates Census income data with more recent economic data to calculate MFIs and uses them to determine eligibility for HUD programs.

MFI divides the distribution of family incomes in a given area in half. This means that half of the families in the area have more income than the median, and half have less. MFIs are established for families consisting of one to eight people. This report will use the number established for a family of four unless otherwise noted. MFIs are useful for understanding the income levels in a given area and for comparing between areas.

The MFI established for Indiana in 2002 was $56,400, similar to the national median income of $54,400. There was considerable variation between the MFI for metropolitan areas versus nonmetropolitan areas—$59,200 as compared to $50,300. MFI varies from a low of $40,800 in Orange County in Region 11 to a high of $64,300 in Dearborn County in Region 9.[34]

In comparison, Supplemental Security Income (SSI), which many people living with HIV/AIDS depend on, paid a maximum of $545 per month to a single person under 65 living alone in 2002.[35] This is equivalent to $6,540 per year, or 12 percent of median income.

[34] U.S. Department of Housing and Urban Development, *Estimated Median Family Incomes for Fiscal Year 2001,* March 2002. Available online: huduser.org/datasets/il/fmr02/index.html (Accessed: August 21, 2002). Dearborn County is considered to be a part of the Cincinnati, Ohio–Kentucky–Indiana metropolitan area, and shares its median income.

[35] Social Security Administration, *SSI Payment Amounts, 1975–2002.* Available online: www.ssa.gov/OACT/COLA/SSIamts.html (Accessed: September 9, 2002).

Every year, the federal government establishes a definition of poverty by using income thresholds based on household size; households that are below the income threshold for that household size are considered to be living in poverty. In 1998, the most recent year for which county-level data is available, the poverty threshold for a single person under age 65 was $8,480 per year, equivalent to $707 per month. For a family of four, including two related children, the poverty threshold was $16,530 per year, equivalent to $1,378 per month.[36]

In Indiana in 1998, 10 percent of residents were living in poverty. The poverty rate ranged from a low of 4.3 percent in Hendricks County in Region 7 to a high of 15.0 percent in Knox County in Region 12.[37] See Appendices 1 through 12 for the most recent MFI available and the percentage of people of all ages living in poverty for each region and county in the state.

Housing Affordability

Housing affordability is determined by the relationship of housing cost to income. HUD considers housing to be affordable if it costs 30 percent or less of the renter's gross income. An area with very high average incomes can still be unaffordable if rents are typically very high; conversely, very low rents can be unaffordable in areas where incomes are low.

Fair Market Rent (FMR) is established by HUD as the rental cost limit for certain rental subsidy programs. FMRs are set for each county at the 40th percentile of rents paid by people who moved within the past two years, excluding people who moved into newly constructed units. This means that 40 percent of rents were lower and 60 percent were higher than FMR. FMR is not intended to represent the actual cost of available units, but is useful as an estimate of housing costs for an area. Appendices 1 through 12 include the Fair Market Rent for 2002 for every county of Indiana, for zero-, one-, two-, and three-bedroom units, by region.

[36] U.S. Census Bureau, *Poverty Thresholds: 1998*. Available online: www.census.gov/hhes/poverty/threshld/thresh98.html (Accessed: August 21, 2002).
[37] U.S. Census Bureau, *Table A98-1,. Estimated Number and Percent People of All Ages in Poverty by County: Indiana 1998.* Available online: www.census.gov/hhes/www/saipe/stcty/a98_18.htm (Accessed: August 21, 2002).

Tables 6 and 7 use FMR to approximate housing affordability for an individual and for a family of four in Putnam County in Region 8. Putnam County is presented because its median income is midway through the range of median incomes reported for the state, and the Fair Market Rent for a one-bedroom apartment is close to the median as well. It is intended to illustrate an "average" county. Each table includes affordability scenarios for a household receiving Supplemental Security Income (SSI), working full-time at minimum wage, and earning 50 percent of median income. Monthly affordability gap is the difference between an affordable rent and the Fair Market Rent.

Table 6:
Housing Affordability for an Individual Living in Putnam County

Income	Gross Monthly Income	Percent of Median Family Income* ($38,220)	2002 Fair Market Rent		Affordable Monthly Rent (30% of Income)	Monthly Affordability Gap	
			Studio Apartment	One-Bedroom Unit		Studio Apartment	One-Bedroom Unit
Scenario One: *Individual receives SSI.*							
Supplemental Security Income (SSI)	$545	17%	$321	$374	$164	$158	$211
Scenario Two: *Individual is employed full-time at minimum wage.*							
Full-time at minimum wage ($5.15/hr)	$893	28%	$321	$374	$268	$53	$106
Scenario Three: *Individual earns 50 percent of Median Family Income.*							
Person earning $19,110 per year	$1,593	50%	$321	$374	$478	none	none

Sources: U.S. Department of Housing and Urban Development, *Estimated Median Family Incomes for Fiscal Year 2001,* March 2002. Available online: huduser.org/datasets/il/fmr02/index.html (Accessed: August 21, 2002).

U.S. Department of Housing and Urban Development, Office of Policy Development and Research, *Fair Market Rents,* 2002. Available online: huduser.org/datasets/fmr/fmr2002F/fmr2002in.pdf (Accessed: August 21, 2002).

Note: Totals may not add up due to rounding.

*For a family of one in 2002. MFI for an individual is calculated as 70 percent of the median income for a family of four.

Table 7:
Housing Affordability for a Family of Four Living in Putnam County

Income	Gross Monthly Household Income	Percent of Median Family Income* ($54,600)	2002 Fair Market Rent		Affordable Monthly Rent (30% of Income)	Monthly Affordability Gap	
			Two-Bedroom Unit	Three-Bedroom Unit		Two-Bedroom Unit	Three-Bedroom Unit
Scenario One: *One adult in household receives SSI.*							
Supplemental Security Income (SSI)	$545	12%	$460	$618	$164	$297	$455
Scenario Two: *One adult in household is employed full-time at minimum wage.*							
Full-time at minimum wage ($5.15/hr)	$893	20%	$460	$618	$268	$192	$350
Scenario Three: *One adult in household earns 50 percent of Median Family Income for 4 people.*							
Person earning $27,300 per year	$2,275	50%	$460	$618	$683	none	none

Sources: U.S. Department of Housing and Urban Development, *Estimated Median Family Incomes for Fiscal Year 2001,* March 2002. Available online: huduser.org/datasets/il/fmr02/index.html (Accessed: August 21, 2002).

U.S. Department of Housing and Urban Development, Office of Policy Development and Research, *Fair Market Rents,* 2002. Available online: huduser.org/datasets/fmr/fmr2002F/fmr2002in.pdf (Accessed: August 21, 2002).

Note: Totals may not add up due to rounding.

*For a family of four in 2002.

Indianapolis

According to federal definition, the Indianapolis metropolitan statistical area (MSA) includes Boone, Hamilton, Hancock, Hendricks, Johnson, Madison, Marion, Morgan, and Shelby Counties. Housing affordability data is presented in several scenarios for an individual in the Indianapolis MSA in ***Table 8*** and for a family of four in ***Table 9***. Monthly affordability gap represents the difference between what a household could afford and what an apartment may actually cost on a monthly basis.

Table 8:
Housing Affordability for an Individual Living in the Indianapolis MSA

Income	Gross Monthly Income	Percent of Median Family Income* ($44,900)	2002 Fair Market Rent		Affordable Monthly Rent (30% of Income	Monthly Affordability Gap	
			Studio Apartment	One-Bedroom Unit		Studio Apartment	One-Bedroom Unit
Scenario One: *Individual receives SSI.*							
Supplemental Security Income (SSI)	$545	15%	$384	$481	$164	$221	$318
Scenario Two: *Individual is employed full-time at minimum wage.*							
Full-time at minimum wage ($5.15/hr)	$893	24%	$384	$481	$268	$116	$213
Scenario Three: *Individual earns 50 percent of Median Family Income.*							
Person earning $22,450 per year	$1,871	50%	$384	$481	$561	none	none

Sources: U.S. Department of Housing and Urban Development, *Estimated Median Family Incomes for Fiscal Year 2001,* March 2002. Available online: huduser.org/datasets/il/fmr02/index.html (Accessed: August 21, 2002).

U.S. Department of Housing and Urban Development, Office of Policy Development and Research, *Fair Market Rents,* 2002. Available online: huduser.org/datasets/fmr/fmr2002F/fmr2002in.pdf (Accessed: August 21, 2002).

Note: Federally established FMR and median income established for the Indianapolis MSA apply to Boone, Hamilton, Hancock, Hendricks, Johnson, Madison, Marion, Morgan, and Shelby Counties. Totals may not add up due to rounding.

*For a family of one in 2002.

Table 9:
Housing Affordability for a Family of Four Living in the Indianapolis MSA

Income	Gross Monthly Household Income	Percent of Median Family Income* ($64,100)	2002 Fair Market Rent		Affordable Monthly Rent (30% of Income)	Monthly Affordability Gap	
			Two-Bedroom Unit	Three-Bedroom Unit		Two-Bedroom Unit	Three-Bedroom Unit
Scenario One: *One adult in household receives SSI.*							
Supplemental Security Income (SSI)	$545	10%	$578	$724	$164	$415	$561
Scenario Two: *One adult in household is employed full-time at minimum wage.*							
Full-time at minimum wage ($5.15/hr)	$893	17%	$578	$724	$268	$310	$456
Scenario Three: *One adult in household earns 50 percent of median household income for 4 people.*							
Person earning $32,050 per year	$2,671	50%	$578	$724	$801	none	none

Sources: U.S. Department of Housing and Urban Development, *Estimated Median Family Incomes for Fiscal Year 2001,* March 2002. Available online: huduser.org/datasets/il/fmr02/index.html (Accessed: August 21, 2002).

U.S. Department of Housing and Urban Development, Office of Policy Development and Research, *Fair Market Rents,* 2002. Available online: huduser.org/datasets/fmr/fmr2002F/fmr2002in.pdf (Accessed: August 21, 2002).

Note: Federally established FMR and median income established for the Indianapolis MSA apply to Boone, Hamilton, Hancock, Hendricks, Johnson, Madison, Marion, Morgan, and Shelby Counties. Totals may not add up due to rounding.

*For a family of four in 2002.

Previous Housing Plans

A number of other housing plans have been completed for the state of Indiana and the City of Indianapolis in the past few years. The primary planning documents are the Consolidated Plans, required by HUD for communities that are applying for community planning development formula grant programs.

The State of Indiana Consolidated Plan Update for 2001 states, "Special needs populations are in need of expanded housing opportunities and supportive services." In a statewide community survey of 347 people, the majority of respondents reported that "the housing and service needs of the homeless, mentally ill, and physically and developmentally disabled were not being adequately met."[38] Specifically, more than a third (39 percent) disagreed with this statement: "The housing and related needs of people with HIV/AIDS are adequately served."[39]

The plan further elaborated that between 1,743 and 2,906 people living with HIV/AIDS in Indiana needed housing,[40] but that only 93 subsidized units in the state were dedicated to housing people living with HIV/AIDS.[41] The challenges cited in the plan for people living with HIV/AIDS in obtaining housing included discrimination, health care needs, and the concurrence of mental illness and substance use.[42] Finally, the plan listed the following needs associated with people living with HIV/AIDS:

- Housing needs: affordable housing for homeless people with HIV/AIDS, housing units with medical support services, smaller apartment complexes, and housing for HIV-positive people in rural areas.
- Community needs: support services for AIDS patients with mental illness or substance abuse problems, medical service providers, public transportation.

The primary resources identified for these needs were HOME through the Indiana Housing Finance Authority, Housing Opportunities for Persons with AIDS (HOPWA), and Section 8.[43]

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[38] Indiana Department of Commerce, *State of Indiana Consolidated Plan: 2001 Executive Summary*, June 30, 2001, p. 4.
[39] Indiana Department of Commerce, *State of Indiana Consolidated Plan: 2002 5-Year Plan,* June 30, 2001, Section III, p. 16.
[40] Ibid, Section V, p. 22. Assumes that 30 to 50 percent of people living with HIV/AIDS need housing.
[41] Ibid, Section V, p. 22. Uses data from the 1997 HIV/AIDS Housing Needs Assessment conducted by Indiana Cares. Includes 46 units in the northern part of the state, 24 units in the southern part, and 22 units in the central part.
[42] Indiana Department of Commerce, *State of Indiana Consolidated Plan: 2001 Executive Summary,* p. 8.
[43] Ibid*,* p. 9. HOME is HOME Investment Partnerships Program, a U.S. Department of Housing and Urban Development-administered program providing grants for low-income housing through rental assistance, housing rehabilitation, and new construction.

In relation to housing affordability in general, not specific to people living with HIV/AIDS, the Consolidated Plan's survey respondents identified the following barriers to housing choice, in descending order:

- Cost of housing
- Public transportation
- Distance to employment
- Lack of accessibility requirements for physically disabled
- Housing discrimination

The City of Indianapolis

The Indianapolis *Consolidated Plan 2000–2004* also discusses housing and services for people with HIV/AIDS as a part of the City's goal related to family self-sufficiency. The goal relates both to addressing the housing needs of very low-income families and supporting their economic self-sufficiency.[44] The *Consolidated Plan* reports that "Death rates among people with HIV/AIDS are decreasing, which may indicate an increase in the level of need for long term housing for people with HIV/AIDS." At the time the Consolidated Plan was written, there were 182 "publicly funded units set aside in Indianapolis for people with HIV/AIDS."[45] More information regarding HOPWA activities in the City of Indianapolis appears in the section "Dedicated Resources."

The City of Indianapolis named several barriers to affordable housing for people in general in its *2002 Action Plan*, which is an update to the *Consolidated Plan 2000–2004*. These barriers are:

- Poor credit history
- High housing costs
- High cost of developing and operating affordable housing[46]

For people living with HIV/AIDS, these barriers could have various implications. People living with HIV/AIDS may have poor credit histories as a result of living on very low incomes and experiencing periods of high medical costs. Property managers often screen applicants out based on their credit history. High housing costs mean that finding housing that is affordable is difficult for many, particularly people with low incomes. Finally, the high cost of developing and operating affordable housing means that the amount of affordable housing developed will be limited, and that it may be more difficult to develop housing units that are set aside for people living with HIV/AIDS.

[44] City of Indianapolis, *The 2000–2004 Consolidated Plan,* November 1999, pp. 1–6.
[45] Ibid, pp. 4–11.
[46] City of Indianapolis, *2002 Action Plan,* November 15, 2001, p. 7.

Housing Market

Census 2000 found that there were more than 2.5 million housing units—including single-family homes and apartments—in Indiana. Of these, 93 percent were occupied and 7 percent were vacant. Of the occupied units, 71 percent were occupied by a homeowner, while 29 percent were rented.[47] This homeownership rate is higher than the rates nationwide in Census 2000: of all occupied units, 66 percent were occupied by owners and 34 percent by renters.[48]

Housing Quality

In addition to affordability, the physical quality of housing is another important characteristic to consider. Some aspects that are commonly used to classify the quality of housing are the presence of plumbing, reliability of heating equipment, availability and safety of electricity, the safety of public areas (for example, working light fixtures, steps, and railings), and other maintenance problems.[49]

Although living in substandard housing has potential health and safety impacts for anyone, there are particular considerations for a person living with HIV/AIDS. For example, adequate hygiene facilities—hot and cold water, a shower—are particularly important for reducing the likelihood of infections. Because many HIV/AIDS medications must be taken with food, having access to a refrigerator can be a substantial aid to medications compliance.

The 2000 Census included some questions about housing quality, including the presence of a complete kitchen, complete plumbing facilities, and telephone service. ***Table 10*** presents data on these characteristics, by HIV Care Coordination Region, as calculated by AIDS Housing of Washington. County-level data appears, by region, in Appendices 1 through 12.

[47] U.S. Census Bureau, *QT-H1: General Housing Characteristics: 2000, Indiana.* Available online: www.census.gov/census2000/states/in.html (Accessed: August 22, 2002).
[48] U.S. Census Bureau, *QT-H1: General Housing Characteristics: 2000, United States.* Available online: www.census.gov/census2000/states/us.html (Accessed: August 22, 2002).
[49] These are components of the American Housing Survey definition of physical problems.

Table 10:
Percentage of Occupied Units with Selected Characteristics, by HIV Care Coordination Region

HIV Care Coordination Region (Major City)	Lacking a Complete Kitchen	Lacking Complete Plumbing Facilities	No Telephone Service
Region 1 (Gary)	<1%	<1%	2%
Region 2 (South Bend)	1%	<1%	4%
Region 3 (Fort Wayne)	1%	1%	4%
Region 4 (Lafayette)	<1%	<1%	2%
Region 5 (Muncie)	<1%	<1%	3%
Region 6 (Anderson)	<1%	<1%	2%
Region 7 (Indianapolis)	<1%	<1%	2%
Region 8 (Terre Haute)	1%	1%	4%
Region 9 (Richmond)	1%	<1%	3%
Region 10 (Bloomington)	1%	1%	2%
Region 11 (Jeffersonville)	1%	1%	3%
Region 12 (Evansville)	1%	<1%	3%
Indiana	**1%**	**1%**	**3%**

Source: U.S. Census Bureau, DP-4, Profile of Selected Housing Characteristics: 2000, Data Set: Census 2000 Summary File 3 (SF 3). Available online: factfinder.census.gov (Accessed: October 14, 2002). Regional data calculated by AIDS Housing of Washington.

Note: Complete kitchen facilities are defined as a sink with piped water, a range or cook top and oven, and a refrigerator, not necessarily in the same room. Complete plumbing facilities are defined as hot and cold piped water, a flush toilet, and a bathtub or shower, not necessarily in the same room. Telephone service is defined as having a telephone in working order that can make and receive calls. Households where service has been disconnected due to nonpayment or other reasons are not counted as having telephone service available.

Housing Authority Resources

Housing Authorities are a major provider of subsidized housing resources across the country, including in Indiana. A HUD database includes 66 housing authorities in Indiana.[50] The 2 housing authority programs most commonly discussed in relation to people living with HIV/AIDS are public housing and the Housing Choice voucher program (Section 8). Public housing is subsidized rental housing for low-income people, owned and operated by a housing authority. Section 8 allows recipients to rent a privately owned apartment but pay a subsidized rent. ***Table 11*** presents an inventory of housing authority resources by HIV Care Coordination Region.[51] Inventory by housing authority appears, by region, in Appendices 1 through 12.

[50] U.S. Department of Housing and Urban Development's Public and Indian Housing (PIH) Information Center (PIC). Available online: www.hud.gov/offices/pih/systems/pic/haprofiles/index.cfm (Accessed: October 15, 2002).
[51] This inventory reflects the total resources in each region, but not their availability.

Table 11:
Housing Authority Resources, by HIV Care Coordination Region

HIV Care Coordination Region (Major City)	Section 8 Vouchers	Public Housing Units	Vouchers for People with Disabilities (included in Section 8 total)
Region 1 (Gary)	3,046	3,081	0
Region 2 (South Bend)	3,622	1,800	180
Region 3 (Fort Wayne)	3,001	1,094	75
Region 4 (Lafayette)	1,448	0	60
Region 5 (Muncie)	1,586	1,072	0
Region 6 (Anderson)	2,808	799	106
Region 7 (Indianapolis)	7,173	2,064	0
Region 8 (Terre Haute)	1,283	1,426	0
Region 9 (Richmond)	1,138	510	0
Region 10 (Bloomington)	2,341	695	75
Region 11 (Jeffersonville)	1,099	1,716	200
Region 12 (Evansville)	3,088	2,116	100
Indiana Family and Social Services Administration	4,408	0	0
Indiana	**36,041**	**16,373**	**796**

Sources: Housing Authority Low Rent Inventory and Section 8 vouchers are available from the U.S. Department of Housing and Urban Development's Public and Indian Housing (PIH) Information Center (PIC). Available online: www.hud.gov/offices/pih/systems/pic/haprofiles/index.cfm (Accessed: October 15, 2002). Vouchers for People with Disabilities are from Ann O'Hara and Emily Cooper, *Section 8 Made Simple: Using the Housing Choice Voucher Program to Assist People with Disabilities,* Technical Assistance Collaborative, Inc., June 2002. Available online: www.tacinc.org/resourcesframe.html (Accessed: October 15, 2002). Additional information on Voucher for Persons with Disabilities and from a National Own Your Own Home listserv dated October 22, 2002.

Notes: Housing authority inventory information has not been independently verified by AIDS Housing of Washington. Inventory represents the total resources of the region's housing authority, not the availability of these resources. "Low rent units" represent public housing inventory, per PIC Help, email communication with AHW, October 16, 2002. Vouchers for People with Disabilities are a tabulation of Mainstream, Designated Housing, and Certain Developments vouchers from an independently maintained database of the Technical Assistance Collaborative, Inc. These vouchers are likely to be included in the Section 8 total from HUD, and are designated specifically for people with disabilities (see www.hud.gov/offices/pih/programs/hcv/pwd). The Indiana Family and Social Services Administration also operates a statewide program that includes 4,408 Section 8 vouchers and 200 vouchers for people living with disabilities.

Homelessness

On a basic level, homelessness results from poverty and the lack of affordable housing. However, individuals and families who are homeless have a wide variety of experiences. People who are homeless may be working, receiving financial benefits such as SSI, or have no income at all. People who are homeless may also have a mental illness, a developmental disability, substance use issues, domestic violence, a criminal history, a lack of child support and childcare resources, language and cultural barriers, some of these, or none of these. All of these factors can affect a person's ability to obtain and maintain a stable housing situation.

People living with HIV/AIDS are at increased risk of homelessness because of the impoverishing effects of the disease. For example, a person who has supported herself on income from employment may experience a substantial reduction in income after becoming disabled. Although disability benefits are an important source of income for people living with HIV/AIDS, it can take several applications over months or years to qualify, and in most cases, disability benefits provide income that is below poverty level. This reduction in income may be accompanied by an increase in medical expenses. For some, HIV/AIDS-related stigma affects the availability of assistance from family and friends. In addition, other factors—including mental illness, substance use issues, and a history of criminal activities—are increasingly found among people living with HIV/AIDS and increase the risk of homelessness. For these reasons, people living with HIV/AIDS may already be seeking assistance in homeless service systems or may be likely to seek assistance in the future.

On any given night, 700,000 Americans are homeless. Over the course of a year, it is estimated that 2 million people experience homelessness in the United States for some period of time.[52] People are homeless in both urban and rural areas. However, there are different issues surrounding homelessness in urban versus rural areas. While a person without a regular place to stay in an urban area may sleep in an emergency shelter or in a public place, people without a place to stay in rural areas are more likely to move in with friends or family until they wear out their welcome, then move into shelter not intended for permanent habitation, including abandoned shacks, vehicles, and campgrounds.[53] This means that people who are homeless in rural areas are less visible, making it difficult to estimate the true extent of rural homelessness.[54]

Nationally, studies have found that people who are homeless in rural areas are more likely to be "white, female, married, currently working, homeless for the first time, and homeless for a shorter period of time" than people who are homeless in urban areas. In addition, domestic violence is more like to be involved, and substance use is less likely to be involved.[55] One study of people living in rural America who were receiving homeless services found that 55 percent had an "alcohol problem," 30 percent had a "mental health problem," and 21 percent had a "drug problem." At the same time, 65 percent of respondents had worked for pay in the past month, but only 12 percent

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[52] National Law Center on Homelessness and Poverty, 1999 estimate cited in National Coalition for the Homeless, *NCH Fact Sheet #2: How Many People Experience Homelessness?* February 1999. Available online: nch.ari.net/numbers.html (Accessed: June 5, 2002).

[53] Patricia A. Post, MPA, *Hard to Reach: Rural Homelessness & Health Care,* National Health Care for the Homeless Council, January 2002, p. 8. Available online: nhchc.org/Publications/RuralHomeless.pdf (Accessed: June 5, 2002).

[54] Housing and Advocacy Council, *Information About Rural Homelessness: The Problem.* Available online: www.ruralhome.org/pubs/infoshts/rhomeles.htm (Accessed: February 4, 2002).

[55] National Coalition for the Homeless, *NCH Fact Sheet #13: Rural Homelessness,* March 1999. Available online: www.nationalhomeless.org/rural.html (Accessed: February 4, 2002).

worked in a job lasting or expected to last at least 3 months. Their median income was $475 during the past month. [56]

Homelessness in Indiana

The state's Consolidated Plan estimated that 4,622 people in Indiana were homeless and living with HIV/AIDS and related diseases, and experienced related service needs. This estimate was based on an estimated homeless population of 30,812 individuals and an HIV incidence rate of 15 percent among people who are homeless in Indiana. This HIV incidence rate was based on national reports and local providers' experience.[57]

Homelessness in Indianapolis

Indianapolis recently completed a homelessness needs assessment and planning process which culminated in a report entitled *Blueprint to End Homelessness: An Initiative of the Indianapolis Housing Task Force*, dated April 18, 2002. Although HIV/AIDS is not addressed specifically, the plan covers many aspects of homelessness and recommended a number of strategies. Because people who are homeless and living with HIV/AIDS may seek assistance through the homeless service system, these principles will affect the availability of assistance for people living with HIV/AIDS. The approach is organized according to the following principles:

- "Housing first" emphasizes getting people who are homeless into affordable housing and preventing homelessness in the first place.
- "Housing plus" connects affordable housing with support services, such as help finding a job, medical care, or mental health treatment.
- A "strengths-based" focus emphasizes building on the strengths and interests of people who are homeless to increase chances for stabilization.[58]

Recommended strategies include:

- Strengthening efforts to prevent people from becoming homeless
- Improving access to, and coordination of, housing and services
- Coordinating service systems for special populations
- Implementing the *Blueprint to End Homelessness* and monitoring effectiveness[59]

Specifically, the plan recommends making 1,700 additional rental units affordable to the poorest of the poor over 5 years, and providing support services for 2,100 people who are housed. The ultimate goal of the plan is to eliminate homelessness in Indianapolis.[60]

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[56] 1996 National Survey of Homeless Assistance Providers & Clients (Burt, 1999), cited in Patricia A. Post, MPA, *Hard to Reach: Rural Homelessness & Health Care,* National Health Care for the Homeless Council, January 2002, p. 8. Available online: nhchc.org/Publications/RuralHomeless.pdf (Accessed: June 5, 2002).

[57] Indiana Department of Commerce, *State of Indiana Consolidated Plan: 2001 5-Year Plan,* Section V, pp. 12–15. In comparison, a total of 7,036 people in Indiana were living with HIV/AIDS as of June 30, 2002, according to the Indiana State Department of Health.

[58] Coalition for Homelessness Intervention and Prevention, *Blueprint to End Homelessness: An Initiative of the Indianapolis Housing Task Force,* April 18, 2002, p. 2. Available online: www.chipindy.org/blueprint.html (Accessed: August 23, 2002).

[59] Ibid, pp. 4–6.

[60] Ibid, p. 10.

The *City of Indianapolis 2002 Continuum of Care* describes services that are available for people who are homeless, including people living with HIV/AIDS, and analyzes unmet needs. ***Table 12*** presents this data.

Table 12:
City of Indianapolis 2002 Continuum of Care Gaps Analysis Chart

	Percent Estimated Need	Number Estimated Need	Inventory	Gap
Homeless Individuals				
Persons with HIV/AIDS	8%	167	81	86
Homeless Persons in Families with Children				
Persons with HIV/AIDS	5%	70	0	70

Source: *City of Indianapolis* 2002 *Continuum of Care*, p. 13.

Indianapolis' *2000–2004 Consolidated Plan* addresses AIDS and related diseases within its section on homelessness, stating that "It is difficult to estimate the number of homeless persons with AIDS or related diseases; however, it is possible that 5 percent of the Indianapolis homeless population is infected." The plan also cites an estimate from a 1999 count of 3,488 people homeless in Indianapolis at a point in time and between 12,500 and 17,000 during the course of any given year.[61] Combining these figures yields an estimate of 174 homeless people living with HIV/AIDS at one time and between 625 and 850 over the course of a year.

Finally, the most recent comprehensive study of homelessness in Indianapolis presents data from 1999. The study was conducted by the Coalition for Homelessness Intervention and Prevention (CHIP) and its report is entitled *The Struggle to Stay Housed: Homelessness in Indianapolis, Statistics and Trends*. People were both surveyed and interviewed. Of 1,133 people surveyed at shelters on a single night in 1999, 2.8 percent reported being treated for HIV/AIDS-related health problems in the past year.[62] Of the 161 people who were interviewed, 5.6 percent reported being treated for HIV/AIDS within the past year.[63] This document also reports that in interviews and surveys, "homeless people cited eviction or inability to pay rent as leading causes of their homelessness."[64]

[61] City of Indianapolis, *2000–2004 Consolidated Plan,* November 1999, pp. 4-1 through 4-4.
[62] Coalition for Homelessness Intervention and Prevention, *The Struggle to Stay Housed: Homelessness in Indianapolis, Statistics and Trends,* December 2001, p. 20.
[63] Ibid, p. 22.
[64] Ibid, p. 4.

Dedicated Resources

There are 2 federally funded programs dedicated to providing housing, medical care, and services for people living with HIV/AIDS in Indiana: the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act and Housing Opportunities for Persons with AIDS (HOPWA). In addition, there are a number of state-funded programs that serve only people living with HIV/AIDS. These dedicated resources constitute the core of housing- and service-related assistance for people living with HIV/AIDS in Indiana. These programs and an inventory of housing units and rental assistance for people living with HIV/AIDS are described in more detail in the following pages.

People living with HIV/AIDS who have low incomes meet their housing needs in the same ways that low-income people without HIV/AIDS do. When it is not possible to obtain low-cost housing on the market or with rental assistance, residents who earn low incomes typically pay a larger percentage of their income toward housing costs than higher-income people, or combine households with others to share housing costs. People living with HIV/AIDS may seek housing assistance or related services in any existing service system and may not necessarily identify themselves as being HIV-positive in these systems.

People living with HIV/AIDS may qualify for assistance based on their income, family status, mental health, or other factors that are not directly related to their HIV infection. At the same time, Indiana has, as many areas do, resources that are dedicated specifically to serving people living with HIV/AIDS. Although these resources cannot serve everyone in need, they assure that a continuum of housing opportunities is available to those who are in need.

This section describes the major federal and state programs in addition to inventorying the housing programs that serve people living with HIV/AIDS. ***Appendix 14*** includes a description of the range of options an HIV/AIDS housing continuum might include. Other federal programs that provide funding for housing low-income people, regardless of HIV status, are described in ***Appendix 15***.

HIV/AIDS-Dedicated Resources

Two federal programs provide funding dedicated to serving people living with HIV/AIDS—the U.S. Department of Health and Human Services Health Resources and Services Administration's (HRSA) Ryan White Comprehensive AIDS Resources Emergency (CARE) Act program and the U.S. Department of Housing and Urban Development's (HUD) Housing Opportunities for Persons with AIDS (HOPWA) program. Both can be used to fund housing programs, although the eligible activities differ between programs.

Information regarding programs that dedicate funds to people living with HIV/AIDS follows.

Ryan White Comprehensive AIDS Resources Emergency (CARE) Act

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, established in 1990, represents the largest dollar investment made by the federal government specifically for the provision of services for people living with HIV/AIDS. Ryan White funds are intended to help communities and states increase the availability of primary health care and support services and increase access to care for underserved populations.

As part of that goal, the Ryan White program allows housing-related assistance as eligible expenditures under Titles I, II, and IV.[65] Eligible housing-related expenditures include housing referral services—assessment, search, placement, and advocacy services—and short-term emergency housing—short-term rental assistance, emergency shelter stays, short-term residential treatment, short-term assisted living, and temporary/transitional housing programs. In Indiana, Ryan White funds are not used to fund housing programs of any type.

Ryan White Title I funds are awarded to metropolitan areas of over 500,000 people with at least 2,000 AIDS cases in the preceding five years. No metropolitan area in Indiana meets these criteria, so no Title I funds are granted to Indiana.

Ryan White CARE Act Title II program funds are awarded to all states based on a formula. Title II funds are dedicated to providing services for people living with HIV/AIDS and to state AIDS Drug Assistance Programs (ADAP). Indiana State Department of Health administers Ryan White Title II funds for the state, which received $9,609,370 for grant year 2002–2003.[66]

[65] Although Indiana receives Ryan White Title III funding, because no housing activities are allowed under Title III, that program is not described here.
[66] Indiana State Department of Health, email communication, August 15, 2002.

Table 13 presents a summary of programs funded (with project sponsor in parenthesis) in Grant Year 2002-2003 by the State of Indiana Ryan White Title II program.

Table 13:
Indiana State Ryan White Title II Program, by Category of Service, Total Expenditure, and Project Sponsor (April 2002 to March 2003)

Category of Service (Project Sponsor)	Total Expenditure	Percent of Total
Health Insurance Assistance Program (HIAP) [Outsourced Administrative Systems, Inc. (OASYS)]	$6,659,500	69%
AIDS Drug Assistance Program (ADAP) (Indiana State Department of Health)	$792,000	8%
Emerging Communities/Enhanced Medical (Harbor Light Salvation Army, Health and Hospital Corporation of Marion County, Indiana University, and Clarian Health Partners)	$750,216	8%
Early Intervention Program (EIP) (Indiana State Department of Health)	$466,800	5%
Quality Management (Indiana State Department of Health)	$144,140	1%
Comprehensive HIV Services Planning and Advisory Council/Consumer Advisory Board (CHSPAC) (Madison County AIDS Task Force)	$36,000	<1%
Congressional Black Caucus/Minority AIDS Initiative (CBC/MAI) (Indianapolis Urban League)	$34,292	<1%
Emergency Assistance (Indiana AIDS Fund)	$30,000	<1%
Administration (Indiana State Department of Health)	$696,422	7%
Total	**$9,609,370**	**100%**

Source: Indiana State Department of Health, email communication, August 15, 2002 and January 28, 2003.
Note: Percentages calculated by AIDS Housing of Washington.

Housing Opportunities for Persons with AIDS (HOPWA)

Housing Opportunities for Persons with AIDS (HOPWA), a program of HUD, provides funding for housing and housing-related services for people living with HIV/AIDS and their families. Eligible metropolitan statistical areas (EMSAs) and states receive direct allocations of HOPWA funding when 1,500 cumulative cases of AIDS are diagnosed in a HUD-determined geographic region.

HOPWA provides grant funds to state and local governments to design long-term, comprehensive strategies for meeting the housing needs of people living with HIV/AIDS and their families.

Participating jurisdictions have the flexibility to create a range of housing programs, including:

- Housing information services
- Project- or tenant-based rental assistance
- Short-term rent, mortgage, and utility payments to prevent homelessness
- Housing development
- Support services

HOPWA grantees may carry out eligible programs themselves, deliver them through any of their administrative entities, select or competitively solicit project sponsors, and/or contract with service providers.

Ninety percent of HOPWA funds are awarded through formula grants, and the remaining 10 percent is awarded through a competitive grant program. HUD awards 75 percent of HOPWA formula grant funds to eligible states and qualifying cities. The remaining 25 percent of formula grant funds is allocated among metropolitan areas that have had a higher than average per capita incidence of AIDS.

In Indiana, the State of Indiana and the City of Indianapolis are eligible for and receive HOPWA funding. The Indiana Housing Finance Authority (IHFA) is the state grantee, while the City of Indianapolis Department of Metropolitan Development is the grantee for the nine counties of the Indianapolis EMSA. The nine counties of the Indianapolis EMSA are: Boone, Hamilton, Hancock, Hendricks, Johnson, Madison, Marion, Morgan, and Shelby.

Outside the Indianapolis EMSA, IHFA distributes funds annually via a competitive funding process. From July 2001 to June 2002, funds were distributed to thirteen agencies in eleven regions of the state. Six activities were funded, with two-thirds of funding allocated for housing-related activities, including tenant-based rental assistance, short-term rental assistance, and operating costs.[67]

[67] Indiana Housing Finance Authority, email communication, July 17, 2002.

Table 14 presents a summary of programs funded from July 2001 to June 2002 by the State of Indiana HOPWA program.

Table 14:
State of Indiana HOPWA Program,
by Category of Service, Allocation, and Percent of Total
(July 2001 to June 2002)

Category of Service	Allocation Amount	Percent of Total
Tenant-based Rental Assistance	$354,183	47%
Short-term Rental Assistance	$139,191	19%
Support Services	$113,134	15%
Housing Information	$50,921	7%
Administration (sub-grantees)	$49,312	7%
Administration (Indiana Housing Finance Authority)	$22,530	3%
Resource Identification	$14,950	2%
Operating Costs	$5,000	1%
Unallocated Funds (to be carried over to 2003)	$1,780	<1%
Total	**$751,001**	**100%**

Source: Indiana Housing Finance Authority, email communication, July 17, 2002.
Note: Percentages calculated by AIDS Housing of Washington.

Table 15 presents the allocation of funds by counties served, project sponsor, allocation amount, and percent of total from July 2001 to June 2002 for the State of Indiana HOPWA program, outside of the Indianapolis EMSA.

Table 15:
State of Indiana HOPWA Program, by HIV Care Coordination Region, Counties Served, Project Sponsor, Allocation Amount, and Percent of Total, Outside of the Indianapolis EMSA (July 2001 to June 2002)

Region	Counties Served	Project Sponsor	Allocation Amount	Percent of Total
1	Lake, LaPorte, Porter	Greater Hammond Community Services, Inc.	$149,700	21%
1	Lake, LaPorte, Porter	The Aliveness Project of Northwest Indiana	$30,000	4%
1	Lake, LaPorte, Porter	Brothers Uplifting Brothers, Inc.	$30,000	4%
2	Elkhart, Fulton, Marshall, Pulaski, St. Joseph, Starke	AIDS Ministries/AIDS Assist of North Indiana	$98,800	14%
3	Adams, Allen, DeKalb, Huntington, Kosciusko, LaGrange, Noble, Steuben, Wabash, Wells, Whitley	AIDS Taskforce of Northeast Indiana	$94,529	13%
4	Benton, Carroll, Clinton, Fountain, Jasper, Montgomery, Newton, Tippecanoe, Warren, White	Area IV Agency on Aging and Community Action Programs	$36,160	5%
5	Cass, Howard, Miami, Tipton	The Center for Mental Health	$26,052	4%
6	Blackford, Delaware, Grant, Jay, Randolph	Open Door Community Services	$41,712	6%
8	Clay, Parke, Putnam, Sullivan, Vermillion, Vigo	Area VII Agency on Aging and the Disabled	$57,372	8%
9	Decatur, Fayette, Franklin, Henry, Ripley, Rush, Union, Wayne	AIDS Task Force of Southeast Central Indiana (Richmond)	$26,907	4%
10	Bartholomew, Brown, Greene, Lawrence, Monroe, Owen	Positive-Link	$52,817	7%
11	Crawford, Jackson, Jefferson, Jennings, Orange, Switzerland, Washington	Hoosier Hills AIDS Coalition/Clark County Health Department	$11,816	2%
12	Daviess, Dubois, Gibson, Knox, Martin, Perry, Pike, Posey, Spencer, Vanderburgh, Warrick	AIDS Resource Group	$70,825	10%
		Total	**$726,690**	**100%**

Source: Indiana Housing Finance Authority, email communication, July 17, 2002.

Notes: Region 7 (Indianapolis) is funded separately through the City of Indianapolis. Percentages calculated by AIDS Housing of Washington.

The City of Indianapolis distributes HOPWA funds for the Indianapolis EMSA annually, utilizing a competitive application process. In 2002, five agencies were funded to serve the nine counties in the Indianapolis EMSA.[68]

Table 16 presents the allocation of funds by agency and the 2002 amount for the City of Indianapolis HOPWA program. A breakdown of funds by activity was not available.

Table 16:
HOPWA-Funded Agencies in the Indianapolis EMSA (2002)

Agency	Allocation
The Damien Center	$525,000
Partners in Housing Development Corporation	$150,000
Ebenezer Church Foundation	$75,000
Indianapolis Urban League	$50,000
Administration (City of Indianapolis)	$19,620
Concord Neighborhood Center	$15,000
Total	**$834,620**

Source: City of Indianapolis, email communication, August 20, 2002.

Other Programs

The Indiana State Department of Health administers four additional programs for people living with HIV/AIDS, including:

- *HIV/AIDS Services Program:* This program is state-funded. This program pays for care coordination at 18 sites throughout the state. Funding for grant year 2002–2003 was $2,500,000.
- *Special Population Support Program:* This program is state-funded. This program provides substance use and mental health support services throughout the state. Funding for grant year 2002–2003 was $1,000,000.
- *HIV/AIDS Education Program:* This program is state-funded. This program pays for prevention and education programs. Funds are sub-granted to community action programs throughout the state. Funding for grant year 2002–2003 was $800,000.
- *Social Services Block Grant:* This program is federally funded. This program also provides care coordination at 2 of the 18 sites throughout the state. Funding for grant year 2002–2003 was $604,830.[69]

[68] City of Indianapolis, email communication, August 20, 2002.
[69] Indiana State Department of Health, email communication, August 15, 2002.

Inventory of Housing Dedicated to People Living with HIV/AIDS

The state of Indiana has a range of housing options available to people earning low incomes, including people living with HIV/AIDS. Each region operates its own housing continuum, which includes emergency shelter, transitional housing, permanent housing, and specialized care facilities. Yet each region has more people living with HIV/AIDS in need of housing assistance than housing programs can accommodate.

Table 17 presents an inventory of the housing programs funded by HOPWA that are dedicated to serving people living with HIV/AIDS in Indiana.

Table 17:
Housing Units, Long-Term Rental Assistance Vouchers, and Short-Term Rental Assistance, by Region, Capacity and/or Number of People Served in 2001, and Total

HIV Care Coordination Region (Major City)	**Program**	**Facility-Based Housing Units** (Capacity of Program)	**Long-Term Rental Assistance** (Number Served in 2001)	**Short-Term Rental Assistance** (Number Served in 2001)
Region 1 (Gary)	Greater Hammond Community Services, Inc.	0	10	41
Region 2 (South Bend)	AIDS Ministries/AIDS Assist of North Indiana	28	19	33
Region 3 (Fort Wayne)	AIDS Task Force of Northeast Indiana	20	29	88
Region 4 (Lafayette)	Area IV Agency on Aging and Community Action Programs	0	15	16
Region 5 (Muncie)	Open Door Community Services	0	1	25
Region 6 (Anderson)	Open Door Community Services	6	5	5
Region 7 (Indianapolis)	The Damien Center	0	71*	112
	Partners in Housing Development Corp.	55	0	0
	Triangle Associates	24	0	0
Region 8 (Terre Haute)	Area VII Agency on Aging and the Disabled	0	13	11
Region 9 (Richmond)	AIDS Task Force of Southeast Central Indiana	0	9	17
Region 10 (Bloomington)	Positive-Link	0	9	32
Region 11 (Jeffersonville)	Clark County Health Department (Hoosier Hills AIDS Coalition)	1	2	2
Region 12 (Evansville)	AIDS Resource Group and Evansville Housing Authority	8-9	7	20
	Total	**142-143**	**190**	**402**

Sources: Indiana Housing Finance Authority, email communication, September 10, 2002. The Damien Center, email communication, September 12, 2002. AIDS Ministries/AIDS Assist of North Indiana, phone communication, September 11, 2002.

* The Damien Center has 11 project-based rental assistance units and 60 tenant-based rental assistance vouchers.

Survey Findings

This section presents findings from surveys of 418 people living with HIV/AIDS throughout the state. A copy of the survey and complete survey data are available in Appendix 16 and Appendix 17. Findings included:

- Survey respondents had very low incomes.
- Many survey respondents received some housing assistance, but most still pay a large portion of their income for housing.
- Consistent with the preferences expressed, the majority of respondents lived alone and rented their homes.
- Behavioral health issues, such as mental health and substance use, affected a small but considerable percentage of people living with HIV/AIDS.
- Many respondents had experienced homelessness.

Overview of the Survey

The consumer housing survey was one of three types of input from consumers provided for the needs assessment and planning process. The other two types included participating on the Steering Committee and in consumer focus groups. The goal of the survey was to assess consumer housing needs and preferences.

The survey was completed by 418 people living with HIV and AIDS in Indiana. Completed surveys were received from people living with HIV/AIDS in each of the twelve HIV Care Coordination Regions in Indiana.

Surveys were distributed by the Indiana Housing Finance Authority and The Damien Center to 22 other agencies that worked on survey distribution and administration.[70] Surveys contained no personal identifiers and were completed anonymously. Consumers who completed the survey received a $5 grocery voucher.

[70] Agencies that distributed surveys included AIDS Ministries/AIDS Assist of North Indiana, AIDS Resource Group, AIDS Task Force of Northeast Indiana, AIDS Task Force of Southeast Central Indiana, Aliveness Project of Northwest Indiana, Area IV Agency on Aging and Community Action Programs, Area VII Agency on Aging and the Disabled, Bridging the Gap, Brothers Uplifting Brothers, Inc., The Center for Mental Health, Community of Love, The Damien Center, Greater Hammond Community Services, Inc., Hoosier Hills AIDS Coalition, Indy Thrift for AIDS, Indianapolis Urban League, Indiana State Department of Health, Division of HIV/STD, Madison County Community Action Group, MATEC, Monroe County Community AIDS Action Group, Open Door Community Services, Positive-Link, and Wishard Health Services Midtown Community Mental Health Center.

Reliability of Data

The demographic profile of survey respondents corresponds closely to the profile of known living HIV and AIDS cases in terms of gender, race/ethnicity, and age. Compared to reported HIV and AIDS cases, survey respondents included more females and fewer males, more people living with HIV and fewer living with AIDS, more respondents from Regions 1, 2, 4, and 9, and fewer respondents from Regions 7 and 11.

Survey Findings

Survey respondents had very low incomes.

The median income reported by respondents was $635 per month, just 14 percent of the Median Family Income (MFI) for a single person living in Indiana ($56,400 annually).[71] In comparison, the federally established poverty level is equivalent to $753 per month.[72] Median reported incomes varied considerably between demographic groups. White/Caucasian respondents reported a median of $700 per month, compared to $560 and $549 for Latino and African American respondents, respectively. The median income reported by men was $673, compared to $545 for women.

Thirty-four percent of survey respondents did not earn any income, from a job or otherwise. Social Security Disability Insurance (SSDI) was the most commonly reported source of income, with 34 percent of respondents, followed by Food Stamps (31 percent), income from employment (27 percent), and Supplemental Security Income (SSI) (21 percent).

Many survey respondents received some housing assistance, but most still pay a large portion of their income for housing.

Forty-one percent of respondents were receiving some type of housing assistance at the time of the survey. The most commonly reported type of housing assistance was HOPWA, reported by 1 in 5 respondents, followed by Section 8 (12 percent), and subsidized or public housing (5 percent). Still, just 11 percent of respondents reported paying less than 30 percent of their income toward housing costs, the limit for affordability set by HUD. Almost a quarter of respondents were paying 30 to 50 percent of their income for housing, and one-third were paying more than half of their income for housing.

Friends and family are also a substantial source of housing assistance for people living with HIV/AIDS. Twelve percent of survey respondents reported living with friends or relatives, including 7 percent who can stay as long as needed and 5 percent who are staying on a time-limited basis.

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[71] U.S. Department of Housing and Urban Development, *Estimated Median Family Incomes for Fiscal Year 2001,* March 2002. Available online: huduser.org/datasets/il/fmr02/index.html (Accessed: August 21, 2002). Dearborn County is considered to be a part of the Cincinnati, Ohio–Kentucky–Indiana metropolitan area, and shares its median income.

[72] U.S. Census Bureau, *Poverty 2001*. Available online: www.census.gov/hhes/poverty/threshld/thresh01.html (Accessed: December 11, 2002). The given poverty threshold is for 2001, the most recent year for which data is available as of December 2002. The poverty threshold is $9,039 annual income for a single adult.

Respondents were asked how they would respond to a $50 increase in their monthly housing expenses. Slightly more than a third (34 percent) indicated that they would apply for more benefits or emergency assistance, while 14 percent indicated they would borrow money from friends or family, and 14 percent would move from their current housing. More than a quarter (28 percent) reported they would be able to pay the increase without making other changes.

Finally, affordability can be a barrier to obtaining housing. When asked about a range of possible barriers to getting or keeping housing, the two most common responses were related to affordability. More than a third indicated they did not have enough money for move-in costs, including security deposit and first and last months' rent (36 percent); a similar proportion (34 percent) were unable to afford the apartments available.

Consistent with the preferences expressed, the majority of respondents lived alone and rented their homes.

When asked about current household composition, the most common arrangement reported by respondents was living alone (40 percent). The second most common was living with a spouse or partner (24 percent), followed by with a child or children (15 percent).

These living arrangements—alone or with immediate family, rather than with friends or other adults—were consistent with the preferences indicated in a later question about sharing housing. When asked to choose a preference if they were to have to move next month, 80 percent said they would rather have a place of their own even if it meant paying more rent, rather than share a place with other people. However, responses about the ability to pay an additional $50 per month in housing expenses, summarized above, indicate that many respondents cannot afford a rent increase.

The majority of respondents (56 percent) rented their apartment, house, condo, or mobile home, and another 6 percent rented a room. Almost 1 in 5 owned the home they lived in.

When asked to rate their satisfaction with their current housing, half of respondents reported being either "happy" or "very happy." Another 29 percent indicated that their "housing is OK." Nine and 8 percent, respectively, reported being "not happy" and "not happy at all." Similarly, when asked about their preference, the majority (57 percent) preferred to stay where they were, while 43 percent preferred to move to another place.

Behavioral health issues, such as mental health and substance use, affected a small but considerable percentage of people living with HIV/AIDS.

Respondents were asked whether they had any disabilities affecting their daily lives. Mental health or psychiatric disabilities were reported by 12 percent of respondents, and alcohol or drug use was reported by a similar proportion of respondents (10 percent).

When asked about their participation in behavioral health care services within the month prior to completing the survey, almost half of respondents had participated in some type of mental health services, including more than a quarter who had seen a counselor. A quarter had participated in a support group, including HIV/AIDS support groups. Nearly one-fifth had participated in substance use treatment or recovery programs.

Although reported by a small percentage, mental health and substance use issues had disrupted housing for some. Three percent reported that mental health had been a barrier to getting or keeping housing, and 4 percent reported that alcohol or drug use had been a barrier. Similarly, 9 percent reported that use of drugs or alcohol had been a factor in their most recent episode of homelessness.

Finally, respondents were asked about their preferences for drug and alcohol use policies in housing. In AIDS Housing of Washington's national work, people living with HIV/AIDS have commonly indicated that they prefer not to live with people with substance use issues, yet many people living with HIV/AIDS have had difficulties maintaining housing that includes sobriety as an eligibility requirement. A nearly two-thirds majority of Indiana respondents preferred housing that requires residents to be clean and sober, while one-third preferred to live in a place where residents would not be evicted for using drugs or alcohol, indicating that both types of housing are needed.

Many respondents had experienced homelessness.

A history of homelessness was fairly common among survey respondents. More than one-third of respondents reported that they had been homeless. Respondents who had been convicted of a felony were more than twice as likely to report past homelessness than respondents who had not.

In addition, 19 percent of survey respondents reported that they had slept in a car, park, the street, or some other outside place since being diagnosed as HIV-positive, and 15 percent had slept in a shelter since being diagnosed.

The factors leading to homelessness reported most commonly by respondents were: no income from a job or benefits, a friend or family made them move, the respondent's use of alcohol or drugs, and eviction.

Respondents had also put themselves at risk in order to put a roof over their heads: 5 percent of respondents had traded sex for a place to sleep and 4 percent had traded sex for money to pay rent.

Focus Group Findings

Eight focus groups were held with 64 people living with HIV/AIDS throughout the state. The focus group format allows for more qualitative and open-ended input from consumers than the consumer survey. Issues discussed in focus groups included housing affordability, housing quality, independence, confidentiality, and recommendations for housing and services for people living with HIV/AIDS. Summaries of each group appear in Appendix 18. Findings included:

- Participants identified affordability as their primary housing challenge.
- Participants were concerned about the quality of housing that is affordable to them.
- Participants expressed a desire to be independent.
- Confidentiality was identified as critical to people living with HIV/AIDS and affects willingness to access services.
- Participants had many recommendations for HIV/AIDS housing and services.

Overview of Focus Groups

Focus groups of people living with HIV/AIDS are a method used to obtain information from consumers that is similar to the survey but more qualitative. The structure of focus groups also allows consumers to identify issues of importance to them that may not have been included in the survey, or approached from the same angle.

A total of eight focus groups were held in Gary (Region 1), South Bend (Region 2), Fort Wayne (Region 3), Indianapolis (Region 7), Richmond (Region 9), Jeffersonville (Region 11), and Evansville (Region 12). A total of 64 people living with HIV/AIDS participated in the groups. These focus groups are summarized individually in ***Appendix 18.***

Participants were recruited by:

- Aliveness Project of Northwest Indiana, Gary (Region 1)
- Brothers Uplifting Brothers, Inc., Gary (Region 1)
- Greater Hammond Community Services, Inc., Hammond (Region 1)
- AIDS Ministries/AIDS Assist of North Indiana, South Bend (Region 2)
- AIDS Task Force of Northeast Indiana, Fort Wayne (Region 3)
- The Damien Center, Indianapolis (Region 7)
- Urban League, Indianapolis (Region 7)
- AIDS Task Force of Southeast Central Indiana, Richmond (Region 9)
- Clark County Health Department, Jeffersonville (Region 11)
- AIDS Resource Group, Evansville (Region 12)
- Indiana Statewide HIV Consumer Advisory Board, District 12 Representative Bud Shipley, Evansville (Region 12)

The following themes emerged in the focus groups.

Focus Group Findings

Participants identified affordability as their primary housing challenge.

In every focus group, consumers commented on how cost and affordability had shaped their housing options. Many described living with roommates or, more commonly, with family members as ways to keep housing more affordable. Participants frequently reported living with parents or other extended family members, or renting housing at low or no cost from family members. Eleven of 64 focus group participants reported receiving housing assistance from their parents or extended family, most frequently by sharing housing. One participant described deriving a sense of self-esteem from caring for an older parent, and a sense of community from being with family. Although family support is critical, it does not guarantee stability. For example, one participant reported living with and caring for an elderly mother in the home that she owns. Although this situation works very well, this participant was very uncertain about how s/he will manage the homeowners insurance, taxes, and utilities after his/her mother passes away, saying "My future scares me to death."

Many focus group participants reported receiving housing assistance, typically either from Section 8 or HOPWA. Many participants receiving assistance commented on its positive impact in their lives. For example, one participant in subsidized housing in Indianapolis said that this apartment was his/her "first apartment under $200 a month," and that it was "good to have housing where money isn't an issue." A participant in Evansville said that s/he had just moved into his/her "dream apartment" using Section 8. In Region 2 (South Bend), however, focus group participants reported that the Fair Market Rent limit for Section 8 was too low for much of the housing that is available, making it difficult to use vouchers, especially in safe neighborhoods. In addition, participants in South Bend also reported that some landlords will not accept Section 8 vouchers.

Participants reported many housing barriers in addition to affordability. The most commonly reported barrier to housing was having a poor rental history, including prior evictions and poor or no landlord references. Similarly, poor credit was reported in a few groups as a barrier to housing. One participant expressed frustration that by the time a person living with HIV/AIDS was desperate enough to seek out housing assistance, his/her credit was likely to be so poor that even using this assistance could be difficult. Having a prior felony conviction was also identified as a barrier. Finally, several participants commented on the difficulty of finding an apartment that would accept pets, and the importance of having pets as companions.

Participants were concerned about the quality of housing that is affordable to them.

In every group, participants raised concerns about the quality of housing that is affordable to them. A common theme was landlords who are slow to make repairs or do not make them at all. One participant stated that asking a reluctant landlord to make needed repairs can result in having the tenant labeled as a "complainer," which can cause other problems. Another participant suggested that it would be helpful to have a record of bad or unreliable landlords; by the time a tenant finds out if a landlord is not a good one, s/he has usually already committed to a one-year lease. Physical quality problems identified specifically included plumbing problems and pest infestation.

Another commonly identified quality issue pertained to the types of neighborhoods where affordable housing is located. A number of participants were concerned that their homes are in neighborhoods with criminal activity, particularly drug-related activity. Participants expressed a desire to be in safer neighborhoods, and described a feeling that unsafe neighborhoods cause more stress, which impacts health negatively. In a Region 7 (Indianapolis) focus group, participants who were in recovery from substance use expressed a desire to live in areas with less prevalent substance use, citing the tension with maintaining sobriety when surrounded by people who are actively selling and using drugs.

Participants expressed a desire to be independent.

Many preferences reported by consumers suggest a desire to be as independent as possible. For example, the majority of participants prefer to live alone or only with immediate family, such as a partner or child. Several participants expressed a preference for a private kitchen and bath, even if other aspects of the housing needed to be shared, citing a need for privacy as well as cleanliness. Many participants expressed a preference for renting a single family home rather than an apartment. Several participants expressed a desire for homeownership; however, homeownership without financial assistance is likely to be unaffordable to many people living with HIV/AIDS. Housing that is physically accessible was identified a few times as a component of maintaining independence; one participant living in a townhouse anticipated needing to move as the stairs become more difficult to manage.

A few participants thought that having more group housing or more opportunities to live with other people living with HIV/AIDS would be helpful. HIV/AIDS-dedicated facilities appealed to some as an affordable source of mutual help and a way to reduce social isolation. Still, the majority preferred to live in housing that is integrated into the community, citing concerns about confidentiality and stress from living with "strangers." One participant described a past experience living in an HIV/AIDS group home as emotionally draining; it was difficult to become attached to people, only to watch them die.

Participants preferred housing that was close to services, hospitals, and public transportation. Many participants did not own their own car, and therefore had to rely on public transportation, friends, and, where available, agency van services. Others had unreliable cars and preferred the independence of walking to appointments or employment.

Finally, participants expressed a desire for employment opportunities that would not endanger their medical benefits. Participants acknowledged that maintaining access to medical benefits is critical, but were interested both in opportunities to earn money and in having a productive way to spend their day.

Confidentiality was identified as critical to people living with HIV/AIDS and affects willingness to access services.

First and foremost, many participants do not want their neighbors or landlord to learn of their HIV status, for fear that stigmatization will result. In every focus group, participants identified privacy, especially regarding their HIV status, as a desirable housing attribute. Privacy is the primary reason that participants did not want to live in an HIV/AIDS-dedicated facility. Although most participants did not cite specific examples of HIV/AIDS stigma at their homes, participants in Region 2 (South Bend) reported vandalism and theft due to discrimination related to sexual orientation.

In several focus groups, participants reported concerns related to accessing HIV/AIDS services or assistance because it identified them publicly as a person living with HIV/AIDS. For example, in one group participants were concerned that receiving rental assistance from the local AIDS service organization meant having a check with that agency's name (which includes the word "AIDS") go directly to their landlord. In Region 12 (Evansville), participants suggested that landlords who accept rental assistance from HOPWA be required to sign a confidentiality agreement.

Participants in another group expressed frustration that accessing the local food bank requires taking a referral, a slip of paper featuring the AIDS service organization's name, to the food bank. Some participants felt that they were treated differently at the food bank after being identified as a client of an AIDS service organization, and were concerned that the ever-changing group of volunteers who staff the food bank did not necessarily treat this information appropriately. Finally, some participants preferred not to receive HIV/AIDS-related mailings, which might be seen by friends or neighbors, as well as mailings with return addresses that feature words like "HIV/AIDS" or "infectious diseases," because these might also compromise confidentiality.

Participants had many recommendations for HIV/AIDS housing and services.

Focus group participants were asked to share their priorities and recommendations for HIV/AIDS housing and services, and contributed a wide array of ideas. A complete list of suggestions appears in the summary of each group in Appendix 18. Frequently suggested and other selected recommendations appear below:

Housing

- Continuation and expansion of resources that are already available: "What they do is pretty good, but they need more."
- Assistance for mortgages and homeowner repairs.
- More permanent affordable housing, perhaps by giving people living with HIV/AIDS priority for Section 8 or by providing HOPWA in a program structured like Section 8.
- More housing for families and related services, such as childcare.
- Housing for people without children.

Services and Benefits

- Reduced paperwork and streamlined application processes for many kinds of programs, in order to reduce the time required of both consumers and service providers, as well as to make assistance available in a more timely fashion.
- More Food Stamps, food pantries, or other food and nutrition resources.
- Assistance that protects confidentiality.
- Home visits from AIDS service providers.
- Increase disability benefits so they provide enough money to live on.
- Employment opportunities that do not endanger medical benefits.
- More HIV/AIDS education for the general public, especially employers.

Resource Identification

- Legal information and assistance, especially for dealing with landlords. This could include information about rights and responsibilities, dealing with poor credit, and protecting confidentiality.
- A source of information about bad landlords, or a way to establish the reliability of a landlord before committing to a lease agreement.
- A central source of information about all the resources available locally. Sometimes a person does not know to ask for help with something, and therefore might not find out about something that could help them.
- Education about how to effectively search for housing and how to be a good renter.

Issues Identified by Key Informants

Issues related to housing and HIV/AIDS were identified and described by nearly 140 housing and service providers, state and local agencies, and funders who were interviewed during the course of the needs assessment process. This section summarizes their input. Themes included:

- Housing
- People with multiple diagnoses: HIV/AIDS and behavioral health
- Expanding populations in need
- Coordinating with multiple service systems
- Housing Opportunities for Persons with AIDS (HOPWA)
- Transportation
- Stigma

Finally, the most frequently identified issues by region are presented. A complete list of stakeholders interviewed appears, sorted by HIV Care Coordination Region, at the beginning of the plan.

The following issues were identified and described by nearly 140 housing and service providers, state and local agencies, and funders from each of Indiana's twelve HIV Care Coordination Regions who were interviewed during the needs assessment. Steering Committee members contributed the original list of potential key informants, and stakeholders identified additional contacts during interviews. The majority of interviews were conducted in person, either individually or in small groups, while others were conducted over the phone. A complete list of people interviewed for the needs assessment appears at the front of this plan.

Key informants were asked about resources already in place to assist low-income people in general, and people living with HIV/AIDS in particular, as well as their perceptions of related unmet needs. Key informants within each HIV Care Coordination Region identified both similar and different issues. Some themes were common to many regions, while others were primarily a concern in just one or a few. Finally, even if an issue was identified in just one region, it may also be a concern in other regions. For example, the housing needs of youth, particularly gay youth, were highlighted in Region 1 only, but it is likely that other regions are experiencing the same need.

A defining consideration for all of the issues identified is that many **people living with HIV/AIDS earn low incomes**. Some people living with HIV/AIDS are unable to maintain a full-time or even part-time job due to the instability of their health, and for this reason may have no income or rely on disability benefits. Disability benefits are often not enough to allow people to live independently; the SSI maximum for a single adult in 2002 was below the federally established poverty level. Meanwhile, others are living in poverty despite being employed (the "working poor"), due to limited education or occupational skills, which hinders their earning potential. In parts of the state, such as Lake County, declining economies and high unemployment significantly limit the economic opportunities available for residents. Income determines a person's ability to pay housing costs, as well as pay for other essentials such as transportation, food, and health care.

Housing

Key informants in every region of the state raised concerns about the affordability and quality of housing available. Within each region, and within each community in a region, there are variations in the local housing market: price of housing, location of housing, physical condition of housing, sizes of apartments that are available, and availability of housing for sale or rent.

Key informants in several areas commented on the high cost of housing, and difficulty in obtaining rental housing, due to the **competition from university students for affordable units**. In particular, this was mentioned in West Lafayette (Purdue University), in Bloomington (Indiana University), and Muncie (Ball State University). Landlords typically raise rents in neighborhoods near colleges or universities due to students' willingness to share housing in order to make it affordable. For example, a landlord may charge $900 per month for a three-bedroom house, which would be unaffordable to many families earning low incomes. However, three students may rent the house and each pay a manageable $300 per month.

Key informants noted that the **location of housing** that is affordable to people earning low incomes is often not close to public transportation and services. In some areas, people with very low incomes, including people living with HIV/AIDS, move to more affordable towns in order to access less expensive and better quality housing. However, moving out of these higher cost areas typically means moving away from services, resulting in transportation problems.

In almost every region of the state, key informants commented on the **poor physical quality** of housing that is affordable to people living with HIV/AIDS. In many areas, property managers of low-rent housing are often not responsive to requests for repairs. These apartments are also typically in the neighborhoods with the highest levels of crime, including drug trafficking. A Kentucky-based HIV/AIDS service provider even reported that volunteer drivers who pick up consumers at home consider there to be a noticeable gap in quality between consumer housing in Kentucky and Indiana's Region 12, with the Indiana side having lower quality housing. **Physical accessibility** is another factor in determining whether an apartment is appropriate for a person with a disability; key informants in several regions commented on the need for more accessible apartments.

Key informants in every region of the state reported a need for **permanent independent housing assistance** to make market rate housing more affordable for people living with HIV/AIDS and other people who earn very low incomes. Many key informants indicated that additional resources to fund long-term tenant-based rental assistance, such as Section 8 or HOPWA, was needed. Throughout the state, it was acknowledged that while the Section 8 program was a vital resource, waiting lists are typically long, making this resource difficult to access.

Most recipients of HOPWA long-term rental assistance vouchers, by program design, transition to Section 8 after a maximum of two years. However, when Section 8 waiting lists are closed or the waiting period is longer than two years, consumers must continue to receive HOPWA rental assistance if they are to remain housed, thereby limiting openings for new people to access long-term HOPWA.

Other suggestions for permanent affordable housing included single room occupancy units, homeownership, and set-aside units in mainstream housing developments.

Barriers to Housing

Some people living with HIV/AIDS experience **barriers to housing** that would make obtaining an apartment difficult even with sufficient funds to pay the monthly rent. These barriers affect other segments of the population as well. First, for people with very low incomes, it is difficult to save enough money for **move-in costs**, including security deposits, in order to obtain an apartment. Even people who have a rent subsidy, such as Section 8, may have difficulty paying move-in costs.

Second, property managers often screen potential tenants for credit risks. Many people living with HIV/AIDS have **credit problems** related to living on very low incomes for years, while some lack budgeting and financial skills. Debts to housing authorities can be a barrier to accessing assistance as well.

Third, a **poor rental history**, including prior evictions, is a barrier to housing because property managers prefer to rent to tenants who they expect to be successful. Even if a person has made changes in his/her life that will improve their chances as a renter, a poor rental history is typically a deciding factor.

Fourth, **criminal history** is a substantial barrier to both private market and subsidized housing for some. While there are sound reasons for excluding people with a criminal history, including an effort to protect other tenants and the property itself, the result is that people with a criminal history often have difficulties finding a place to live, which complicates their efforts to lead a stable life. Criminal history, particularly drug-related offenses, also impacts eligibility for Section 8, public housing, and other programs.

In an effort to address some of these barriers, housing and service providers in Fort Wayne have developed the Gold Star Landlord-Tenant program to train both landlords and tenants in their rights and responsibilities. Those who complete the program can use their certification to attest to their suitability as potential landlords or tenants.

Housing Authorities

Housing authorities are the **largest housing providers** in many areas of the state (see Appendices 1 through 12 for an inventory of public housing and housing vouchers by region). Housing authorities typically provide two types of housing assistance: public housing and Section 8 housing vouchers. Public housing is facility-based, while Section 8 vouchers allow people to live in market-rate units while paying rent that is affordable to them.

In many areas of the state, providers reported that people on **waiting lists** for public housing or housing vouchers do not receive housing assistance for at least one year due to the large existing demand. In addition, many housing authorities in the state have closed their waiting lists, due to the number of people waiting and the lack of vacancies. Often, the demand for **housing vouchers** exceeds that for public housing, since many people prefer to choose an apartment that is integrated into the community rather than live in a designated facility. In some areas, providers also reported concerns about drug-related activities in public housing.

Housing authorities have discretion over what priority they place on housing for people with disabilities. For example, housing authorities can choose to apply to the U.S. Department of Housing and Urban Development (HUD) for **Mainstream Section 8 Vouchers**, which are set aside for people with disabilities. A number of housing authorities already have Mainstream Section 8 Vouchers (see Appendices 1 through 12 for an inventory by region), and others reported applying during the needs assessment process. Some housing authorities have established **local priorities** for their Section 8 vouchers and designate some vouchers for certain programs or projects; for example, people with disabilities are prioritized for Section 8 assistance at the Elkhart Housing Authority (Region 2).

A number of housing authorities interviewed during the needs assessment process expressed a willingness to work with AIDS service organizations to explore **partnerships** to increase housing opportunities for people living with HIV/AIDS. Many service providers reported that they had good working relationships with their local housing authorities, although agencies varied in the types of relationships they had. For example, many social services agencies assist people living with HIV/AIDS as they apply for housing authority resources. Others have formalized agreements regarding set-aside vouchers, project-based vouchers, or priorities for certain groups.

Some key informants indicated that people living with HIV/AIDS are interested in homeownership. A few housing authorities in Indiana are offering HUD's newly allowable **Section 8 home ownership** programs. These programs permit people to use Section 8 vouchers to purchase a home, and clearly open doors for people who would not otherwise be able to purchase a home. However, because HUD has established a federal income minimum that exceeds annual SSI payments for a single person, and because participants need to obtain a private mortgage (i.e. have good enough credit to secure a mortgage),[73] it is unlikely that many people living with HIV/AIDS, particularly those who are single, would be able to purchase a home even with this program.

Need for Housing with Services

Many key informants throughout the state, particularly homeless service providers, reported that there were more homeless people than the **emergency shelters** in their communities could serve. In addition, because many emergency shelters are designed to serve a certain segment or segments of the population, people who are not in these categories may not be served. For example, in Elkhart (Region 2) and Terre Haute (Region 8), the only shelters for men and women are faith-based and abstinence-based, limiting their suitability for some. In Richmond (Region 9) and Evansville (Region 12), specific populations in need of shelter include men with substance use issues and women with children, respectively.

In addition to the needs that other people who are homeless have, people who are homeless and living with HIV/AIDS often need a place to stay inside during the day, especially in severe weather. Some regions of the state do not have shelters that allow people to stay inside during the day, while other regions only open their shelters for the winter months. Homeless service providers in Fort Wayne (Region 3), for example, described a need for a housing or shelter respite program for people who are homeless and physically ill.

[73] Ann O'Hara and Emily Cooper, *Section 8 Made Simple: Using the Housing Choice Voucher Program to Assist People with Disabilities*, Technical Assistance Collaborative, Inc., June 2002. Available online: www.tacinc.org/resourcesframe.html (Accessed: October 15, 2002).

In many regions, key informants identified a need for **transitional housing** opportunities for people living with HIV/AIDS and others who are homeless or at risk of becoming homeless, particularly those who need support services related to behavioral and physical health. For example, a key informant in Indianapolis (Region 7) identified a need for short-term supportive housing for people who need medical assistance upon being released from the hospital, as many of these people are being referred to emergency shelters. A provider in Richmond (Region 9) commented that it was especially difficult to place families in transitional housing, because most programs targeted single adults.

Key informants identified a need for additional **permanent supportive housing opportunities** in many regions of the state. For people with behavioral and physical health issues, such as HIV/AIDS, mental illness, developmental disabilities, and substance use, it is difficult to maintain stable housing without support services. While some people benefit from these services in the short term, such as in transitional housing, others need them indefinitely. Many of the permanent supportive housing opportunities in the state are located in Indianapolis (Region 7), which has recently completed a planning process (*The Blueprint to End Homelessness*) that focused on the difference that permanent supportive housing can make to the community.

In several regions, key informants discussed the need for housing that included **medical care**. In the earlier days of the epidemic, people living with HIV/AIDS experienced a rapid decline in health and tended to die quickly. Today, with newer medications accessible to many, people with HIV/AIDS live longer and healthier lives. For this reason, HIV/AIDS housing is no longer focused on hospice care and end-of-life issues. However, people living with HIV/AIDS still face periods where they need intensive medical attention. Some people are diagnosed with HIV after years of being infected, or were diagnosed years earlier but did not pursue health care until they experienced a decline in health, and therefore are facing health problems at a more advanced stage. Key informants indicated that Hispanics/Latinos, African Americans/Blacks, and/or people with substance use issues are more likely than others to be diagnosed in the later stages of the disease.

In many regions of the state, housing for people living with HIV/AIDS with intensive medical care needs is not available. Many nursing homes are not accepting people living with HIV/AIDS, resulting in referrals to Chicago (for residents in the northern part of the state) or Indianapolis. In addition, a key informant with a statewide focus identified a lack of housing opportunities for people whose needs were not great enough to warrant nursing home care but who still needed regular medical attention.

Other Types of Housing Assistance

The need for more emergency financial assistance for **homelessness prevention** was identified in several regions. Key informants described a need for additional sources of temporary financial assistance (1 to 2 months) to help with rent and utilities. For example, a Ryan White Title III clinic in Kentucky uses money from their general fund to assist Indiana consumers in Region 12 when HOPWA funds are depleted.

For all people who have low incomes, and for the working poor in particular, Township Trustees are an important resource. All townships are required to provide “poor relief,” but the amount of funding each township has varies. Typically, Township Trustees focus on emergency assistance with food, rent, and utilities. This is an important safety net for people with no other resources,

including people who are waiting for a decision on an application for SSI, Temporary Assistance for Needy Families (TANF), or Food Stamps.
A few key informants described a need for **mortgage assistance** for people living with HIV/AIDS who own their own homes. This is a particular need among those who may lose their home due to an inability to pay their mortgage. One key informant described a local home-share program for seniors in which a person looking for a home is matched with a senior homeowner, allowing seniors to keep their homes longer, while providing companionship for both participants. Although this program is senior-focused, people living with HIV/AIDS who own their own homes could potentially benefit from a similar program.

Key informants also identified the need for some specific services that would help people develop skills to obtain and maintain their housing. Several key informants discussed the importance of **budgeting and money management skills** and the impact on a person's ability to obtain and keep housing when these skills are lacking. One key informant commented that protective payee services are available for some people with disabilities, and that more people might benefit from such an arrangement. Housekeeping was also mentioned; some people would benefit from learning **housekeeping skills**, while others are less able to clean and would benefit from **chore services**.

People with Multiple Diagnoses: HIV/AIDS and Behavioral Health

Many key informants commented on the difficulties that **people with substance use issues and/or mental illness** have in finding and keeping a stable housing situation. HIV/AIDS service providers commented in particular on the prevalence of substance use issues among people living with the disease. Perceptions of the extent to which mental illness affects people living with HIV/AIDS varied greatly.

Key informants reported a need for more **transitional housing** opportunities for people coming out of substance use treatment. In Evansville (Region 12), for example, transitional housing for women in recovery was identified as a particular need that the community is mobilizing to address.

Key informants more frequently identified a need for **permanent housing** that is appropriate and affordable for people with mental health and/or substance use issues. Many providers reported that people with mental health and/or substance use issues need regular access to support services, whether on- or off-site, in order to remain stably housed. Some providers reported that scattered-site housing programs for this population, such as Shelter Plus Care, would be more effective than facility-based programs. Several areas report that using the Shelter Plus Care program to serve this population has been very effective, but that more resources are needed.

Some providers commented on the difficulty of **housing people who are actively using substances**. Many housing programs require residents to be clean and sober, which means that people who are not clean and sober cannot access most housing resources. Yet, as one provider stated in relation to this population, "We could keep him sober if we could keep him housed." Some providers believe that creating housing based on a harm reduction or Safe Haven model would be beneficial, but that the expected challenges in building community support for such a program make providers reluctant to address this need.

In most regions, key informants did not express concern about the access that people living with HIV/AIDS, and others, have to **substance use treatment services** when they are ready to access

them. However, key informants in some regions of the state indicated that a variety of substance use treatment services were needed. For example, a key informant in Region 11 reported that more substance use treatment was needed in that area, particularly for women and minorities, as traditional treatment models may be less effective for women and people of color. In addition, a provider in Region 12 reported that detox services are more available than residential treatment in that region. Another key informant stressed the importance of having treatment options that address both a person's HIV/AIDS and substance use issues at the same time, as these issues are often intertwined.

A number of providers commented on recent cuts in the state hospital system that have had an impact on community providers, and reported a need for additional **community-based mental health services**. Key informants indicated that some people seem to fall between the mental health and developmental disabilities systems; some people who seem to need both services are eligible for neither or only one program.

Expanding Populations in Need

Many key informants, particularly those in Indianapolis (Region 7), commented on issues related to serving diverse populations. Increasingly, people living with HIV/AIDS include African Americans, Hispanics/Latinos, and people who have been incarcerated. Although these issues were raised primarily in relation to the Indianapolis metropolitan area, national trends suggest that these issues may increasingly affect other regions in the state in the future.

Agency Capacity and Cultural Competency

In response to working with expanding and changing populations, established AIDS service organizations indicated that they are increasing their outreach and adapting their services to better serve people of color, women, families, people with behavioral health issues, and people who have been incarcerated. At the same time, agencies have formed and are trying to form to offer more specialized services. These smaller and newer organizations struggle with the application and reporting requirements of funders, as well as with trying to expand their administrative capacity to attract and retain qualified staff.

Despite efforts to improve access to services for expanding and changing populations, longstanding AIDS service organizations are linked in popular conception to the groups they started serving—primarily gay white men. In Indianapolis, this issue has sparked emotion from consumers and providers alike. Several providers commented on the benefit of allowing organizations to focus on particular segments of the population, such as African Americans/Blacks, to help ensure that culturally competent services are available to consumers. In addition, one provider commented on consumers' desire to work with care coordinators who "look like them"—meaning, who are of similar racial/ethnic background. Other key informants felt that consumers do not desire care coordinators of similar race/ethnicity, as long as they are being served well.

African Americans/Blacks

Key informants noted the disproportionate impact HIV/AIDS has had on **African Americans/Blacks** in Indiana. Particularly in Indianapolis (Region 7) and in Gary (Region 1), organizations have formed that focus primarily on serving African Americans/Blacks. However, key informants also noted that programs specializing in serving African Americans/Blacks are scattered throughout the state.

Finally, one key informant, not in HIV/AIDS services, commented that s/he had not encountered African Americans in decision-making roles at the local AIDS service organization or at the state level, and wondered if there was adequate representation of African Americans/Blacks in decision-making positions.

Hispanics/Latinos

Throughout the state, agencies that serve people living with HIV/AIDS are beginning to serve more **Hispanics/Latinos**. Many agencies are beginning outreach efforts to identify Hispanics/Latinos who are not currently receiving medical care or support services. These agencies are trying to engage monolingual Spanish speakers and/or undocumented immigrants. Key informants noted that there are not enough bilingual staff and/or translators to meet the need. Agencies are focusing on outreach to this population because many Hispanics/ Latinos are reluctant to seek health care or services, due to cultural norms and/or fear of deportation. In addition, like many people living with HIV/AIDS, Hispanics/Latinos are reluctant to disclose their HIV status, even to family and friends. Many Hispanic/Latino men are working low-paying, manual labor jobs, and are sending much of their earnings to families in their home country and/or are supporting a family in Indiana. For undocumented persons, few resources are available. However, more resources are available in Indiana than in their home country, so many stay in the United States in order to continue to receive medical care.

People Who Have Been Incarcerated

Many providers also discussed people who **are or have recently been incarcerated**. Because an increasing percentage of Americans have been incarcerated, and because substance use issues increase the likelihood that a person will have both HIV and a criminal history, an increasing number of people living with HIV/AIDS are or have recently been incarcerated.

Some HIV/AIDS service organizations work closely with local and state corrections programs; activities include HIV testing, ensuring that prisoners are discharged with medications and a place to stay, and providing information about HIV. However, it is more common that people living with HIV/AIDS are released after receiving limited health care and are sent to emergency shelters with little discharge planning. For this reason, more coordination between jails and prisons and HIV/AIDS service providers would be beneficial. Some reported that the medical care received by people living with HIV/AIDS who are incarcerated could be improved, although recent changes at the state level, including transitioning responsibility for medical care for inmates from the Department of Corrections to the Department of Health, may improve inmates' access to medical care and coordination with HIV/AIDS service providers.

Coordinating with Multiple Service Systems

In most regions of the state, housing and social service providers reported strong connections between agencies at the level of service provision. Most non-HIV/AIDS service agencies contacted were familiar with the HIV/AIDS service organization in their area and felt comfortable about making referrals. HIV/AIDS service organizations did not report problems with accessing existing community services outside of HIV/AIDS-specific services.

Despite this, many key informants not directly involved in HIV/AIDS housing commented that local AIDS service organizations are not usually active participants in **local housing and service planning and coordinating groups**, where local housing needs are discussed. Probably for this reason, many providers not working directly on HIV/AIDS housing issues reported that they did not have much, if any, information about HIV/AIDS housing needs, and in many cases did not perceive people living with HIV/AIDS as a population with housing needs. Many providers, however, reported an interest in learning more about people living with HIV/AIDS and their needs.

One reason that AIDS service providers may not be participating in local-level planning groups is that their consumers are able to access services adequately already, therefore limiting the need for additional collaboration. While many support services have become more accessible to people living with HIV/AIDS over time, people living with HIV/AIDS may also be less urgently in need of assistance than in the past because of improved health. Another reason may be that, at a national level, AIDS service organizations were developed to meet needs that mainstream organizations would not. In addition, many AIDS service organizations have continued to work alone.

Housing Opportunities for Persons with AIDS (HOPWA)

Key informants raised a number of issues related to planning for HIV/AIDS housing at the state level. A number of key informants commented on the lingering effects of **the dissolution of AIDServe Indiana** several years ago. Although everyone who discussed this acknowledged that this experience is in the past and that everyone is moving on, it is clearly fresh in many providers' minds. For example, a few organizations were still resolving lingering financial issues during the course of the needs assessment. Others commented on the impact that the statewide organization's dissolution had on the perception of AIDS service organizations locally. Key informants noted that the side effects of AIDServe Indiana's negative publicity included fewer landlords willing to participate in HOPWA and decreasing success in local fundraising efforts.

A few key informants commented on the **state's HOPWA allocation process and the administration of the HOPWA program** by the Indiana Housing Finance Authority (IHFA). One key informant felt that too many decisions that affect the entire state were made in Indianapolis, without sufficient participation from regional representatives. Another found the HOPWA allocation process unclear; this provider wanted to be an advocate for meeting the needs of his/her region, but was unsure of the most effective or appropriate way to become one. Some HOPWA providers reported that the HOPWA reporting requirements implemented by IHFA were cumbersome. Since taking over administration of the HOPWA program, IHFA has increased monitoring and compliance in response to the accounting and reporting problems with the program

before IHFA took over administration. Key informants indicated that they understood the reasons for the increased monitoring requirements.

One developer indicated that there would be an increased likelihood of **developing HIV/AIDS housing** outside of Indianapolis if the State of Indiana used some of its HOPWA funds on new construction or rehabilitation. Although a number of key informants stated that the capacity to develop affordable housing in their area is limited, some reported that there is a strong network of development consultants working statewide. A few smaller organizations that had developed special needs housing reported being burned out on the complexity of the development process and dealing with community opposition.

However, **AIDS service organizations did not indicate an interest in developing housing** for people living with HIV/AIDS, or in partnering with developers. First, although most AIDS service organizations identified housing as a major need of the people they serve, they do not identified their missions as housing-focused. Rather, most AIDS service organizations are primarily concerned with medical care, food and nutrition, and emergency assistance.

Second, most AIDS service providers equate facility-based HIV/AIDS housing with **group homes** and facilities that house people living with HIV/AIDS only. Because many providers believe these older and more common models are no longer appropriate for many, they are disinclined toward pursuing development options. Reasons that providers are not supportive of the group home idea include: (1) many people living with HIV/AIDS have longer and healthier lives and prefer housing integrated into the community, and (2) more people living with HIV/AIDS have substance use or mental health issues that make shared living without a structured program difficult.

Many key informants commented on **discrepancies in the HIV/AIDS services that are available regionally**. In reality, the resources and population density vary between regions, so there are practical considerations that make it unlikely that every type of service will be available in every region. Still, some providers expressed frustration at needing to refer some consumers out of the service area in order to access assistance, or that they may need to advise consumers to actually move to a neighboring county in order to access assistance. For example, a provider in Region 1 reported needing to send at least 6 people with special needs out of Porter County to access assistance. Many key informants indicated that their clients had to seek some services, usually medical care, in Indianapolis. In some cases, people even needed to leave the state to access the nearest services—approximately half of the clients of Matthew 25 AIDS Services in Henderson, Kentucky are actually from Indiana, while some consumers in Region 1 receive medical care in Chicago.

In at least one case, geographic disparities in services are due to the **geographic emphasis of funding sources**. For example, the Louisville, Kentucky metropolitan area recently started to receive a HOPWA formula grant that covers 4 counties of Indiana, and Indiana HOPWA funds are not available to residents of those 4 counties. These counties are served by the Clark County Health Department in Jeffersonville, which reports disparity in access to HOPWA within their HIV Care Coordination Region. There is a waiting list for assistance in the 4 counties of the Louisville metropolitan area that they serve, while people living in the other 10 counties, included in Indiana's HOPWA program, can access assistance right away. In Madison County, key informants indicate that consumers are confused about where and how to access services, as they are part of HIV Care Coordination Region 6, but are considered a part of Indianapolis' HOPWA eligible metropolitan statistical area.

Transportation

Many key informants commented on the lack or limited availability of public transportation in their area. This impacts the ability of people living with HIV/AIDS to access housing, services, and employment. As a result, some service providers spend time and resources transporting consumers and/or staff members to access needed services. Several Township Trustees reported that assistance for car repairs is frequently requested by low-income people generally, even though it is typically not available. One service provider in Region 11 indicated an interest in trying to provide more services via the Internet, such as education or training and information dissemination, so that transportation is less needed.

Stigma

Throughout the state, key informants indicated that the general population stigmatizes people living with HIV/AIDS. The impact of the stigmatization of people living with HIV/AIDS is felt in many ways, including access to care, housing, services, and employment. In addition, many people living with HIV/AIDS lose the support of their family, friends, and churches. The result is that many people are, in the words of one key informant, "in denial about their HIV status instead of in care."

Accessing Care

According to many key informants, the stigma that exists among the general population in Indiana regarding HIV/AIDS contributes to reluctance by many people living with HIV/AIDS to access medical care or other services. Key informants indicated that the stigma associated with certain agencies, particularly those with the word "AIDS" in their name, kept some people living with HIV/AIDS away from services. It was noted that this was particularly common in rural areas and among Hispanics/Latinos and African Americans/Blacks. The names of many agencies in the state do not make it immediately obvious that they serve people living with HIV/AIDS. However, even agencies with non-AIDS-specific names may have some stigma associated with them, due to a general acknowledgement in the community that the agency serves people living with HIV/AIDS.

Stigma, according to key informants, also contributes to the preference of many people living with HIV/AIDS to live independently, rather than in supportive housing for people living with HIV/AIDS. While some people are willing to live in HIV/AIDS-specific housing, others fear disclosure to neighbors, friends, and family.

Some key informants indicated that nursing homes and housing, mental health, and substance use providers were homophobic and/or HIV-phobic, resulting in limited opportunities for care among people living with HIV/AIDS.

Not in My Back Yard (NIMBY)

The stigmatization of people who earn low incomes, have mental health or substance use issues, have been homeless, and/or are living with HIV/AIDS has hindered proposed housing programs for these populations, according to key informants. The "not in my backyard" syndrome, or NIMBY,

has caused many key informants to become discouraged about developing housing for people living with HIV/AIDS. One key informant indicated the she was willing to manage the development of every aspect of a new housing project except getting neighborhoods to agree to accept a housing project for people living with HIV/AIDS in their "backyard."

Issues Identified by Region

The following are issues that were raised repeatedly in each region and seem to be common concerns or themes. However, there was not a consensus among key informants in each region, nor were these the only issues identified.

Region 1 (Gary)

Key informants in this area reported that:

- Stigma about HIV limits access to care and housing. For example, many consumers do not want to live in HIV-only programs, due to confidentiality concerns, and many people living with HIV/AIDS have lost support even from family and friends due to HIV/AIDS-related stigma.
- AIDS service agencies and other agencies that serve people living with HIV/AIDS report some disconnect, and a need to improve coordination and planning.
- Safe, decent housing is scarce in northern Lake County, but more available in other parts of the region; at the same time, services are more accessible outside northern Lake County.

Region 2 (South Bend)

Key informants in this area reported that:

- Unemployment and low-paying jobs greatly impact housing options, while barriers to housing, including poor credit, criminal histories, and affordability, are prevalent.
- Housing development capacity in the region is high, and the largest developer is committed to serving people living with HIV/AIDS. In addition, the regional AIDS service organization has development capacity.
- Housing for people with substance use issues, including transitional and permanent supportive housing options, is limited.

Region 3 (Fort Wayne)

Key informants in this area reported that:

- There is a great unmet need for affordable permanent housing; for example, Section 8 has a lengthy waiting list.
- People with medical needs and people with mental illnesses would benefit from more housing opportunities that include a support services component.
- Public transportation is limited, which can be a barrier to accessing employment and services. Service outreach is costly and difficult to fund.

Region 4 (Lafayette)

Key informants in this area reported that:

- Many people living with HIV/AIDS have physical and mental health issues that preclude them from working and living independently.
- Primary housing needs in the area are for emergency assistance and long-term rental assistance for people who cannot afford high housing costs.
- People living with HIV/AIDS access services at an agency that serves a broad population with diverse programs, allowing anonymity and convenience for consumers.

Region 5 (Muncie)

Key informants in this area reported that:

- Housing development for people with special needs and low incomes has been extremely difficult in Muncie due to community opposition. As a result, apartments for people with very low incomes are scarce.
- Emergency financial assistance and emergency shelter beds are limited.
- Many clients are able to live independently, but need rental assistance in order to find a decent unit in a safe, low-crime neighborhood.

Region 6 (Anderson)

Key informants in this area reported that:

- People needing emergency, transitional, or permanent supportive housing generally have to go to Indianapolis for assistance, making consumers in this region very dependent on Indianapolis.
- The recent addition of a HOPWA provider based in this region has greatly increased the number of people receiving housing assistance.
- Many people living with HIV/AIDS have substance use and/or mental health issues.

Region 7 (Indianapolis)

Key informants in this area reported that:

- African Americans/Blacks and Hispanics/Latinos are an increasing portion of those living with HIV/AIDS. While services have been established targeting African Americans, services for Latinos are limited, but growing.
- HIV/AIDS services in the region, which are all based in Indianapolis, are divided among several agencies. Available housing resources vary based on the provider a consumer is associated with, sometimes necessitating referrals.
- Capacity of smaller HIV/AIDS service organizations is limited, but growing.
- Many people living with HIV/AIDS have physical and behavioral health issues that do not allow them to successfully live independently, and/or have histories (credit, rental, criminal) that are a barrier to successfully securing housing and/or housing assistance.

- Some consumers prefer to access services at agencies other than The Damien Center, because many perceive the agency as closely associated with gay white men, despite the diverse population it now serves.

Region 8 (Terre Haute)

Key informants in this area reported that:

- Homeless services are well coordinated, and housing authorities prioritize special needs populations; however, housing for people living with HIV/AIDS is not acknowledged as a special need.
- Current HOPWA resources are adequate to serve existing consumers. The majority prefer to, and have the ability to, live independently.
- Temporary or emergency housing is needed; just one shelter serves the six-county region, and its faith-based program requirements are not a good fit for some consumers.

Region 9 (Richmond)

Key informants in this area reported that:

- Transitional housing is needed for people who require support services, have exhausted their opportunities with local service providers, and are currently living in a shelter or are homeless.
- Many consumers have credit, rental, and criminal histories and lack money management skills.
- Housing is unaffordable to many, and units that are within reach are substandard.

Region 10 (Bloomington)

Key informants in this region reported that:

- There are many nonprofit social service organizations serving a range of populations; some key informants believe that coordination is needed more than new programs.
- Although local providers are now looking forward after a past negative experience with an HIV/AIDS dedicated facility, the experience is still fresh for many and clouds their consideration of HIV/AIDS housing issues.
- Bloomington is a higher cost area, partially due to the presence of the university. Many identified a need for more permanent affordable housing, including Section 8.
- Many were concerned about people with bad credit, poor rental histories, and/or criminal histories who have difficulty obtaining housing, as well as people who are using substances.

Region 11 (Jeffersonville)

Key informants in this region report that:

- Jeffersonville's housing and services providers are well connected both to each other and to providers in Louisville.
- There is inconsistent access to HOPWA rental assistance. Consumers in the 10 counties funded by Indiana's HOPWA grant can access assistance right away, while there is a waiting list for the 4 counties funded by Louisville's HOPWA grant, due to the higher demand in the 4 more urban counties.
- Stakeholders identified a need for more permanent affordable housing.
- Legal issues, including poor credit and criminal history, were identified as housing barriers for some people living with HIV/AIDS.

Region 12 (Evansville)

Key informants in this region reported that:

- A Title III clinic in Henderson, Kentucky serves many people living with HIV/AIDS from this region; people from Indiana make up half of its clients. This agency provides emergency financial assistance from its general fund to Indiana residents at times when Indiana's HOPWA is unavailable.
- There is growing consensus that more transitional housing is needed for women in recovery from substance use.
- Key informants identified a need for additional food and clothing resources for people living with HIV/AIDS.

Critical Issues

The following issues were identified by the Steering Committee based on the survey data, focus group findings, key informant interviews, and the expertise of the committee members. Committee members determined that these were the most critical issues in housing people living with HIV/AIDS in Indiana. Issues were divided into the following areas:

- Comprehensive and collaborative statewide and local planning
- Affordability
- Barriers to achieving and maintaining housing stability
- Successful tenant-landlord relationships
- Access to community and support services

The Steering Committee met over two days in January 2003 to review the findings from the needs assessment, identify the most critical issues concerning housing people living with HIV/AIDS in Indiana, and develop recommendations to address the critical issues. The issues were grouped into five themes presented on the following pages.

Comprehensive and Collaborative Statewide and Local Planning

The Steering Committee and many stakeholders acknowledged that **strong and effective housing and service systems** are currently in place throughout Indiana. For example, there are HIV/AIDS service organizations dispersed throughout the state that have strong working relationships with housing and social service organizations at the level of service provision. There are housing developers and development consultants who are experienced with supportive housing, as well as strong networks for planning housing and homeless services. These assets create a solid base for providing housing and services to people with disabilities and/or low incomes in Indiana.

Although HIV/AIDS service organizations identify housing as a significant need of people living with HIV/AIDS, **linkages between the HIV/AIDS services and mainstream housing systems need improvement**. Most significantly, HIV/AIDS service organizations are not typically regular participants in their local housing and homelessness planning efforts, such as Continuum of Care, Consolidated Plan, and public housing authority planning processes. For this reason, stakeholders working in housing and homelessness have limited understanding of HIV/AIDS housing needs in their communities, although many expressed an interest when interviewed.

HIV/AIDS service organizations are generally **not as aware of programs and funding sources for housing** as they are of programs and funding sources for services. As a result, most HIV/AIDS service organizations turn primarily to HOPWA for housing resources. Although a critical source of support, HOPWA funds are insufficient to meet demand. Relying solely on HOPWA funds limits the availability of housing assistance and the types of assistance that can be offered. Because state and federal funding sources have different eligibility criteria and allowable activities, it can be difficult for both providers seeking funds and consumers of these programs. Participating in local planning processes is an excellent way to share and obtain information about available resources.

Some stakeholders commented that the more established domestic violence, developmental disability, and mental health service systems are much more sophisticated about accessing housing resources, and may serve as examples to the HIV/AIDS service system.

The Steering Committee emphasized several philosophies in regards to housing planning. There is a growing sense that a **"housing first"** approach—addressing housing needs prior to service needs, rather than vice versa—is most appropriate for people living with HIV/AIDS, as well as other populations. In addition, there is a sense from both providers and consumers that **permanent housing should be a priority**, instead of requiring consumers to move through shelters and transitional housing, although these types of housing meet important needs. Both providers and consumers prefer **independent housing that is integrated into the community, whether rented or owned**. Consumers and providers also commented on the importance of housing that does not segregate people based on income level or special needs. **Physical accessibility** is an important part of appropriate housing. Also, both providers and consumers emphasized the importance of creating opportunities for consumers to make choices about what is best for them.

Finally, the Steering Committee acknowledged that there is already **more need for housing and services than current levels of state and federal financial support can address**. Planning must include responses to the lack of resources, both by prioritizing the use of limited resources and by seeking new resources.

Affordability

The Steering Committee, consumers, and other stakeholders all identified **affordability as the primary barrier to accessing housing for people living with HIV/AIDS**. The consumer survey conducted during this needs assessment found that the median income of respondents was $635 per month, or just 20 percent of Indiana's median income for a single person[74] and below poverty level. Many people living with HIV/AIDS receive the maximum Supplemental Security Income (SSI) payment as their sole income; in 2002, this was $545 per month, or just 17 percent of median family income.

In every region of the state, it is extremely difficult to find decent, safe, and sanitary housing that is affordable for people with such low incomes. The U.S. Department of Housing and Urban Development set 30 percent of gross income as the limit for housing costs to be considered affordable. At the same time, the Fair Market Rent for an efficiency apartment in Indiana ranges from $299 in many counties of the state to $440 in Lake and Porter Counties. These rents are 47 to 69 percent of the median income reported by people living with HIV/AIDS in the survey, substantially higher than HUD's 30 percent guideline.

In addition to the monthly rent, prospective tenants must also pay **deposits and other move-in costs**, such as first and last months' rent and the costs for establishing utility service. Even for people with enough income to pay rent, saving enough money to move in to a house or apartment is difficult.

[74] Median family income for a single person in 2002 was $38,220 according to the U.S. Department of Housing and Urban Development. This is equivalent to $3,185 per month. Poverty level for a single person in 1998 was $8,480 per year, or $707 per month.

The resulting need for affordable housing and housing assistance by people living with HIV/AIDS and other people with low incomes, including people with disabilities, has created demand that greatly exceeds supply. As a result, many areas of the state often have **lengthy waiting lists** for the few housing opportunities that exist.

Barriers to Achieving and Maintaining Housing Stability

In addition to a lack of affordable housing, the Steering Committee, consumers, and providers identified several significant barriers to achieving and maintaining housing stability. The barriers identified most frequently by providers were:

- Poor credit
- Recent criminal history
- Poor rental history, including prior eviction and money owed to property managers
- Active substance use

Survey respondents reported experiencing these same barriers:

- 1 in 5 reported bad credit as a barrier to housing.
- Almost 1 in 5 (17 percent) reported a criminal history, and 2 percent reported it had been a barrier to housing.
- 10 percent of respondents reported being disabled by their substance use, and 4 percent reported it had been a barrier to housing.

Consumers and providers also frequently referred to **confidentiality** as a concern in achieving and maintaining housing stability. Specifically, consumers were fearful that, upon determining their HIV status, property managers and neighbors would react negatively, possibly with eviction or harassment. While some actions by property managers or neighbors may be illegal and covered by Fair Housing law, others are more subtle, as well as legal, but can lead to a person feeling unwelcome in their home.

Other housing barriers for people living with HIV/AIDS include **family size**, acceptance of **pets**, and **accessibility** of housing for people who have physical disabilities. Steering Committee members indicated that providers, funders, and consumers need to address these issues collaboratively.

Finally, both providers and consumers agreed that program requirements that are administratively burdensome can be an impediment to accessing assistance. **Administrative requirements**, such as applying for programs and maintaining eligibility, can be challenging for some consumers, particularly those with low literacy levels, and as a result require more time and effort of direct service providers. Although there are many legitimate reasons for most administrative requirements, there may be opportunities to streamline requirements and reallocate resources.

Successful Tenant-Landlord Relationships

The Steering Committee identified successful tenant-landlord relationships as another critical component of housing success. Both consumers and providers expressed concerns that a lack of **understanding about rights and responsibilities** can lead to housing problems. Consumers expressed an interest in more information about tenant responsibilities, as well as information about how to identify and access housing opportunities and reliable property managers. In addition, 70 percent of survey respondents indicated that they would use legal help to deal with past or current housing problems, such as eviction, if available. In Fort Wayne, the Gold Star Landlord-Tenant program has recently been developed to provide more education to both landlords and tenants and serves as a local example on how to address this issue.

Confidentiality was the aspect of successful tenant-landlord relationships mentioned most frequently by consumers. Consumers suggested that property managers who accept HOPWA be required to sign a confidentiality agreement that would protect the tenant. Providers also stressed that consumers would benefit from trainings on protecting their own confidentiality and making good choices concerning when and with whom to share information about their HIV-status.

Finally, **housing quality** was another aspect of successful tenant-landlord relationships that was identified. In some communities, the housing that is most affordable to people with very low incomes may be of low or even substandard quality. Consumers and providers throughout the state expressed concerns with housing quality. Housing paid for through HOPWA is subject to HUD's Housing Quality Standards (HQS), about which more education is needed; however, many consumers live in housing that is not subject to such quality controls.

Access to Community and Support Services

The Steering Committee identified access to community and support services as a critical component of housing success for many people living with HIV/AIDS. Many people living with HIV/AIDS have support service needs, although access to care varies. Some consumers have difficulty accessing services even though these services are offered in their community, mostly due to **challenges with transportation**. Some areas, particularly those that are rural or suburban, are not served extensively or at all by public transportation. Housing choices are diminished by dependence on inadequate public transportation, particularly considering that half of survey respondents reported traveling 11 miles or more for medical and service appointments. The majority of survey respondents depended on the car of a friend or family member to access appointments. For some, transportation assistance to medical or service appointments is more available than transportation elsewhere, such as the grocery store.

As people with HIV/AIDS live longer and healthier lives, **employment** is increasingly an area of interest for both consumers and providers. In focus groups, consumers expressed an interest in having employment opportunities that would both increase their income and allow them to contribute in their community. At the same time, both providers and consumers highlighted the critical importance of maintaining eligibility for medical benefits.

Recommendations

The following recommendations were developed by the Steering Committee to address the critical issues, summarized in the previous section. Recommendations include seeking additional resources for HIV/AIDS housing, developing leadership for plan implementation, improving coordination with other systems both locally and statewide, and expanding into new program areas. The recommendations are presented in the order in which they were prioritized by the Steering Committee.

The Steering Committee met over two days in January 2003 in Indianapolis, Indiana to review the findings from the Indiana HIV/AIDS housing needs assessment. The meeting was a forum for identifying the issues most critical to housing people living with HIV/AIDS in Indiana and developing recommendations to address these issues.

Consumer Input Into Recommendations

People living with HIV/AIDS were involved in the needs assessment process in three ways: participating in focus groups, completing a housing survey, and participating in community and Steering Committee meetings. During each of the eight focus groups, participants were encouraged to provide solutions to the housing issues they had identified during the meeting. Their ideas, summarized in the "Focus Group Findings" section of the plan, were presented to and discussed by the Steering Committee.

Development and Prioritization of Recommendations

Steering Committee members had the opportunity to brainstorm and develop recommendations in response to the findings of the needs assessment. In addition, the ideas of people living with HIV/AIDS, summarized in the "Focus Group Findings" section of the plan, were presented to and discussed by the Steering Committee. Participants built consensus for seven recommendations to address the critical issues, then prioritized them by level of importance.

The recommendations are listed below as they were prioritized by the Steering Committee.[75]

[75] See Appendix 13 for minutes from the January 16, 2003 Steering Committee meeting, which includes a list of recommendations and the number of priority votes each recommendation received.

Recommendations

1. Seek additional sources of funding to expand housing options along the HIV/AIDS housing continuum.

- Additional funding sources for housing programs include HOME, Community Development Block Grants (CDBG), Shelter Plus Care, Supportive Housing Program, Emergency Shelter Grants, Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, and others.
- New housing programs should be developed based on the needs and preferences identified by consumers during this planning process.
- New housing programs should be developed based on the needs identified for each region of the state.

2. Create a statewide committee to coordinate HIV/AIDS housing planning.

- The mission of the committee is to guide the implementation of the plan's recommendations, as well as to provide educational and technical assistance on HIV/AIDS housing issues throughout the state.
- The Committee should have representatives from each region of the state and should explore possible structures for participation in order to choose the most appropriate and effective model.
- The Committee should have broad participation in order to engage many stakeholders in developing solutions. Participants should include HIV/AIDS housing and services providers, people living with HIV/AIDS, mainstream housing providers (such as developers and housing authorities), property managers, disability service providers, state and local government representatives, and funders.

3. Encourage HIV/AIDS service organizations and other providers that serve people with disabilities to participate in housing and homelessness planning efforts, such as the Consolidated Plan, Continuum of Care and public housing planning processes.

- The recommended statewide HIV/AIDS housing committee should educate stakeholders about the importance of participating in these planning processes.
- Information gathered during this needs assessment and planning process regarding the housing needs of people living with HIV/AIDS should be highlighted during these planning processes.

4. Develop a tenant-landlord education program that could be implemented in each HIV Care Coordination Region of the state.

- The goal of this program is to reduce barriers to accessing housing.
- Investigate model programs from throughout the country, including Fort Wayne's Gold Star Landlord-Tenant program.
- Explore potential funding options for this program.

5. Improve local service coordination among providers in each HIV Care Coordination Region of the state.

- Promote an exchange of information between HIV/AIDS housing and service providers and providers from other services systems, such as homeless, mental health, substance use, and other systems serving people with special needs.
- Seek opportunities to collaborate in planning and in creating housing for people with special needs.

6. Increase housing opportunities for people with barriers related to credit, criminal, and rental histories.

- Collaborate with other systems serving people with barriers to housing, including substance use treatment, mental health, and homeless service systems, in state and local planning processes and on the statewide HIV/AIDS housing committee.
- Make accurate, up-to-date information regarding the needs of this population available to funders, elected officials, and other policy makers.

7. Develop a clearinghouse for information on housing assistance available to people living with HIV/AIDS that will be accessible to consumers and their advocates throughout the state.

- Information should at a minimum include resources dedicated to serving people living with HIV/AIDS.
- Information could be expanded to include all resources that are available to serve and/or house people with very low incomes.
- Information would need to be updated on a regular basis and distributed widely.